FACTORS INFLUENCING CONSUMER DECISION-MAKING PROCESS IN THE PRIVATE HEALTH INSTITUTIONS

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FACTORS INFUENCING CONSUMER DECISION-MAKING PROCESS IN THE PRIVATE HEALTH INSTITUTIONS

by

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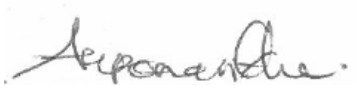
DECLARATION

I, the undersigned hereby declare that the dissertation entitled, Factors Influencing Consumer Decision-Making Process in the Private Health Institutions, is my own work and that it has not been previously submitted to another university for assessment or acquisition of another degree. All sources used in the dissertation have been correctly indicated and acknowledged.



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ABSTRACT

The development that has taken place in the health care sector includes all factors that have brought changes in the consumer decision-making process regarding the private health institutions. In Nigeria, the development is evident in the delivery of the health care services. This indicates that the private health institutions deliver quality health care service by using efficient and quality medical equipment. However, there is a growing awareness among clients to perform an extensive search before the purchase of health care service and the increased expectation from health care quality by clients and their family. The change in consumer behaviour has caused a shift in the consumer decision-making process due to the availability of several sources of information and various health institutions they can choose from. The purpose of this study is to investigate the factors that influence the consumer decision-making process that can enhance customer satisfaction and reduce cognitive dissonance. In this study the behaviour of consumers is related to how they make decisions along several stages before they make a purchase and in a health care setting the decision-making process refers to the process that clients pass through in making choices on alternative health institutions.

The quantitative research method was adopted in this study in describing, analysing and interpreting data. A structured questionnaire was employed to collect primary data from 450 respondents in Lagos state, Nigeria. The primary data was statistically analysed using five stages, namely, exploratory factor analysis, Cronbach's alpha reliability testing, descriptive statistics, multiple regression analysis, and Pearson correlation analysis.

The empirical results of this study indicates that service encounter experience, personal income and support sources are significantly related to the decision-making process. The decision-making process also has significant positive relationship with both customer satisfaction and cognitive dissonance. This indicates that influential factors that have been identified through the empirical results enlighten researchers and the private health institutions on issues that influence the clients' decisions to utilise private health institutions. The well-being and satisfaction of clients will be enhanced if the private health institutions can craft effective strategies that will

enable clients to gain easy access and utilise health care services. This study emphasised that access to and utilisation of health care services in the private health institutions can be granted to clients through personal income and support sources from family members and private health institutions. Futhermore, health insurance coverage is an effective way that will help clients overcome the financial constraints and restricted access to and utilisation of private health institutions.

The study further reveals that the well-being and satisfaction of clients will be enhanced if private health institutions improve access to quality health care. Failure to improve the overall quality and performances of the health care services in the private health institutions can lead to clients' cognitive dissonance. Both private and public health institutions should play a major role in providing the necessary facilities that can assist the clients in their decision-making process regarding their health care needs. This will enable the health care institutions' staff to understand what clients value and need and, therefore, how well to satisfy them and reduce cognitive dissonance. Easy access and utilisation of the private health institutions as well as satisfaction in quality health care delivery will create better health outcomes for the workforce and citizens of a country and this will improve economic development.

Keywords: Private health institutions, consumer decision-making process, predisposing and enabling factors, customer satisfaction and cognitive dissonance.

CHAPTER ONE
SCOPE AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION TO THE STUDY

The creation of goods and services forms the core of economic life in any society. The economic life is centered on how wealth is created through the creation of goods and services and how it is distributed and consumed locally or internationally through import and export. The creation and marketing of goods and services in all sectors enhance sustainability in any economy. In other words, proceeds of income generated from the creation and distribution of goods and services are distributed across states in the county to improve its society (Kurtz & Boone, 2010:5).

The sectors of an economy include the primary sector (raw materials), secondary sector (manufacturing) and tertiary sector (services). The service sector is an important part of a country's economy that provides services that are intangible. Activities in the service sector include hotels and accommodation, education, airlines, information technology, administrative and support services, financial services and health care service. The service sector has become a dominant force in many national economies. According to Akehurst (2008:1), the service sector is responsible for providing 70% of total employment to a country's workforce. Kotler and Keller (2011:380) suggest that service sector will provide 14.6 million jobs by 2018. There will be a 96% increase in total employment in the service sector as compared to the goods-producing sector that will provide a 12.6% of total jobs. Furthermore, the service sector is responsible for the prosperity, development and transformation in many national economies.

This transformation and development come as a result of most countries' involvement in outsourcing their services which promote international trade and investment in the service sector (OECD, 2007:7). These activities have created an additional value in the service sector share of GDP in the past 25-30 years for all countries. The value added percent of the world's service sector GDP reveals an increase of 65% in 1993 to 71% in 2010 (Lee & Wolpin, 2006:1; World Bank Search, 2013:1). The health care sector is a significant part of the service sector in a

country's economy. Therefore, the health care service is a necessity for everyone and is the most important service that clients purchase without information about its actual cost (Berry & Bendapudi, 2007:111). According to Holhut (2011), the stability of a country's well-being depends on the health care service delivery. Furthermore, there exists a direct relationship between health care and economic vitality. This indicates that better access to health care service is expected to result in the following:

- improvement of the welfare of the citizens of a country;
- improvement of employees' (work force) capability to perform duties; thus, their earning potential will result in economic boost;
- improvement of the early development of childhood; and
- reduction of mortality rate.

Therefore, the impact of the health care sector and economic vitality plays a major role in the upliftment of the welfare of the society. Thus, the Nigerian government at the federal, state and local levels continuously strives to provide health care services to its citizens. The government, at various levels, is a major provider of an accessible and affordable health care service that is based on primary health care to all Nigerians (Federal Ministry of Health Abuja, 2004:9). The Federal Ministry of Health Abuja (2004:9) suggests that in order to improve the economic condition and welfare of Nigerians, the three tiers of government aimed to:

- provide basic health education to its citizens;
- promote the supply of food and proper food nutrition;
- provide an adequate supply of safe water and basic sanitation;
- provide maternal and child health care planning (family planning) that is compatible with the cultural and religious belief of its citizens;
- provide immunisation against infectious diseases and the treatment of common diseases;
- provide essential drugs and supplies; and
- promote a programme based on mental health and oral health.

The government at various levels provides a primary health care service that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources. Moreover, individuals and communities are assured of productivity, social well-being, productive lives and enjoyment of living (Federal Ministry of Health Abuja, 2004:9).

Despite the Nigerian's government attempt to create a reformation in the public health institutions, the majority of clients are inclined to purchase health care services from private health institutions. In other words, the purchasing decision of clients has shifted from the public health institutions to the private health institutions (Shops Project-USAID, 2010:4). According to Awofeso (2013), the shift in clients' decision-making behaviour regarding the use of a private health institution is a result of clients' dissatisfaction with public health institutions services that they have experienced. Irrespective of the dissatisfaction experienced by these clients, Kurtz and Boone (2010:152) stipulate that the increasing and immediate shift in the choice of health care service regarding health institutions is a result of the perceived improved health care service rendered in a private health institution.

Clients often make choices due to their perception of the benefit they can acquire from a health institution. They search for a health institution that can provide an improved health care service which is appropriate to their needs. The search for an improved health care services regarding health institution has created a change in consumer (client) behaviour (Dubois, Jolibert & Muhlbacher, 2007:204). Clients are increasingly exploring more information about the health care service from various health institutions and they also gain more knowledge about the benefit they can get from the health institution before purchase of the health care service (Javadi, Dolatabadi, Nourbaksh, Poursaeedi & Asadollahi, 2012:83).

Consumer behaviour refers to the study of the buying behaviour of consumers. In other words, it studies how clients select a health institution, how they buy and make use of health care services to satisfy their need for wellness (Strydom, Jooste & Cant, 2000:71). According to Kurtz and Boone (2010:134), consumer behaviour is the process which a client passes through in order to make a final decision on the purchase of health care service. Strydom *et al*. (2000:71) stipulate that an

understanding of consumer behaviour will assist health institutions to answer why clients choose the private health institution over the public health institution or how they make these choices along the decision-making process, and how the health institutions can make use of this information to retain and attract clients. This indicates that a health institution that better understands the behaviour of its clients will provide an improved health care service that will satisfy its clients and grow its clientele base (Dubois *et al*., 2007:20).

The consumer decision-making process regarding the use of health institutions refers to the step by step process before the actual purchase of a health care service. This process commences before the actual purchase of the health care service and continues after the purchase of the health care service. In the consumer decision-making process, clients are influenced by several factors before they make a decision on what health institution to purchase health service from (Armstrong & Kotler, 2005:160). Mullins, Walker and Boyd (2008:98) state that the more health institutions understand the consumer behaviour and the consumer decision-making process, the greater their ability to:

- design attractive and improved health care services;
- develop marketing programmes that will fit the desire and needs of their clients;
- define and target meaningful market;
- satisfy existing clients and attract new ones; and
- gain competitive advantage over other health institutions.

1.2 PROBLEM STATEMENT

Health care service is an important service that every country requires. Most role players such as the government, trade-unions, and charities have made an effort to deliver adequate health care services to meet the health care need of its population (Cristian, 2009:184). According to Patry, Morris and Leatherman (2010:6), a country's stability and sustainability will depend on how healthy its population is. In other words, the reduction in mortality rate and a healthy work force that performs

work duties is likely to promote economic activities which will in turn increase the country's wealth.

Despite government's ability to create a sustainable and affordable health care service, the health care sector, worldwide, is going through a phase of turbulence. Numerous clients have questioned the health care services provided by the public health institution and private health institutions as it has been seen to be worsening. This situation is evident in the poor management structure, poor government funding, difficulty in accessing health care professionals, shortage of staff, shortage of drugs and medical supplies, long waiting time, lack of medical equipment and deteriorating facilities (Penchas & Shani, 1995:10; Sakyi, Atinga & Adzei, 2012:180).

Major problems facing the Nigerian health care sector are the national health system's low level of funding, poor commitment to health care service in the rural areas; high infant and maternal death, emigration of health care professionals to other countries, poor staffing, poor organisational structure and sales of counterfeit and expired drugs, access to quality health care services is either restricted or non-existent. There is a lack of proper facilities, equipments, medical supplies and inadequate remuneration of public health institution staff (Awofeso, 2013:1; Ogunlela, 2011:82).

Additionally, Ogunlela (2011:81-82) and Onwujekwe, Onoka, Uzochukwu and Hanson, (2011:2) state that the Nigerian health care sector is said to have the following problems:

- incessant strikes by resident doctors and medical personnel;
- unqualified medical personnel;
- erroneous diagnosis of ailments by some laboratory technicians and doctors;
- lack of adequate enforcement of laws guiding medical practise by the health sector regulators such as the National Agency for Food and Drug Administration and Control, Nigeria Medical Association, Federal and State Ministries of Health as well as Pharmaceutical Council of Nigeria; and

- the National Health Insurance Scheme (NHIS) conceived to provide medical coverage for users under the scheme is alleged to have only less than 5% of an estimated 170 million populated Nigerians.

These problems have become a common feature in the public health institutions. Due to these problems, the Nigerian health care system is undergoing rapid changes. Such change is evident in the radical shifts in clients' decision-making process. Many clients are inclined to consider the use of the private health institutions because of the problems present in the public health institution. The search for a better and improved health care service has stimulated changes in their decision-making process (Holder & Berndt, 2011:389; USAID, 2008:11).

The changes in clients' decision-making process have aroused the attention of private health institutions. The changes in clients' decision-making process have heightened unregulated competition amongst private health institutions in Nigeria in a bid to keep up with the needs of clients (USAID, 2008:12). In other words, several private health care institutions are making conscious efforts to better satisfy their clients, retain clients and understand the rationale behind their decision to use private health institutions. The rationale must be clearly understood by the private health care provider because of the intimate relationship that exists between the clientele and health care provider (Leventhal, 2008:54).

However, to better understand the influencing factors on the clients' decision-making process regarding private health institution, the focus of this study will answer the questions: What influences clients to choose the private health institutions? Are clients satisfied with the health care service delivery by the private health institutions or do they desire to have a medical scheme to cover the continuously rising fee of the private health institutions?

1.3 THEORETICAL MODEL OF THE STUDY

Andersen and Newman (2005:14) propounded a theoretical framework of individual determinants of health service utilisation. The theoretical framework proposes that the decision to use private health institutions is a function of clients' predisposing

characteristics (demographic, social structure, and beliefs), enabling characteristics (family and community) and illness level characteristics (perceived and evaluated). The Andersen and Newman's (2005) theoretical framework was also emphasised in the work of Chakraborty, Islam, Chowdhury, Bari and Akhter (2003:328), who discover that the predisposing, enabling and need characteristics are the major factors that influence the use of maternal health care service. The findings reveal that a high level of association exists between the predisposing factor, enabling factor and the use of maternal health care service (Chakraborty *et al.*, 2003:335). The Andersen and Newman's (2005) theoretical model was also employed by Varenne, Petersen, Fournet, Msellati, Gary, Ouattara, Harang and Salem (2006:3) to study the illness-related behaviour and utilisation of oral health services among adult city dwellers. They reveal that the predisposing, enabling and need characteristics will influence clients' utilisation of oral health care. The study findings reveal that the socio-economic level of the household and socio-cultural factors such as religious practises, regional differences and attitudes have a significant influence on clients' use of oral health care services.

The Andersen and Newman's (2005:14) theoretical model put forward three factors, namely, the predisposing, enabling and illness level. According to Andersen and Newman (2005:14), these factors determine clients' utilisation of health care services.

The predisposing factors comprises demographic (age, gender, marital status and past illness), social structure (education, race, occupation, family size, ethnicity, religion, residential mobility), and beliefs (values concerning health and illness, attitudes towards health care service and knowledge about diseases). Chakraborty *et al*. (2003:330) indicate that the predisposing characteristics assert that clients with different predisposing characteristics have a tendency to use more health care service when compared to others. This indicates that the clients' decision-making process regarding the use of health care service is influenced by their predisposing characteristics such as age, gender, education and family size.

Mekonnen and Mekonnen (2002:2) indicate that gender (male and female) as part of the predisposing characteristics in their study showed that females are likely to make

more decision on the use of health care service than male. Amin, Shah and Becker (2010:2) state that the ability to use more health care services can be predicted by individual characteristics. They argue that certain characteristics (age, and parity of the mother, occupation and educational level of the husband) exhibited by different clients will influence their utilisation of health care service. Therefore, the predisposing characteristics comprise factors that influence the decision-making process of clients regarding the use of private health institutions (Fosu, 1994:1209).

The enabling factors in the Newman and Andersen's (2005:14) theoretical model explain the availability of resources that influence the clients' decision regarding the use of health care service. In a practical sense, the decision to utilise health care service will not come into play in the absence of the enabling characteristics. Moreover, enabling factors are measured by family (income, health insurance coverage, type and access of regular sources of third party payment). Enabling factors also stretch beyond the family economic situation to the community (ratios of health, personnel and facilities to population, prices of health services and regions of country urban-rural character). The enabling factor asserts that the decision to utilise health care service is influenced by the realities that exist in a community (Andersen & Newman, 2005:14). Furthermore, the balance or relationship between the amount of health personnel and facilities that are available in a community has a direct bearing on the decision to utilise health care service in that particular community.

The third factor in the Andersen and Newman's (2005:14) theoretical framework is the illness level. The illness level consists of perceived and clinically evaluated dimensions and accounts for nearly every cause of health care service use. The perceived dimension of illness level is determined by the number of days that an individual is rendered not efficient. Further determination of perceived illness includes symptoms that an individual experiences in a space of time and a self-report of general state of health (Andersen & Newman, 2005:25). The clinically evaluated aspect of illness level relates to attempts at getting to the real factors that trigger the illness. It revolves round ascertaining the severity of the illness by health care providers (Gochman, 1997:157).

On the strength of Andersen and Newman's (2005) behavioural model of health service utilisation, the theoretical model for this study is developed. The modified theoretical model provides a broader approach in researching the factors that influence consumer decision-making process regarding the use of private health institutions and the clients' outcome (customer satisfaction or cognitive dissonance) after the decision-making process. The modified theoretical model consists of five components which expands Andersen and Newman's (2005:14) perspective. The expansion is the incorporation of the Hoffman, Czinkota, Dickson, Dunne, Griffin, Hutt, Krishnan, Lusch, Ronkainen, Rosenbloom, Sheth, Shimp, Siguaw, Simpson, Speh and Urbany (2005:177) integrated model of the consumer decision-making process, customer satisfaction and cognitive dissonance. The modified theoretical model comprises the following below:

- Independent variables: Predisposing and enabling factors.
- Mediating variable: Consumer decision-making process.
- Dependent variable: Customer satisfaction and cognitive dissonance.

Each variable and its attributes will be discussed below to get a better understanding of the modified theoretical model.

1.3.1 Independent variables

The predisposing and the enabling factors form the independent variables in the modified theoretical model. Each of these independent variables and their attributes will be discussed below.

- The predisposing factor consists of demographics, social structure and beliefs that clients hold about the private health institutions. It is proposed, in this study, that the predisposing factor influences the clients' decision-making process regarding the private health institution. The characteristics and attributes of the predisposing factor will be discussed below.

❖ Demographics: The demographics characteristic in the modified theoretical model is defined by the clients' age, gender and marital status.

- Age in this study refers to the life span of clients that is qualified to assume certain civil rights and responsibility. The age range of clients in this study falls between 18 and above. Wunderlich (2010:52) indicates that the use of health care service is age related, that is, clients are expected to have a shorter life span due to the inaccessibility of health care services for cure of major health problems.
- Gender in this study relates to biological characteristics that define male and female.
- Marital status in this study refers to clients that are single, married, divorced, and widowed.

❖ Social structure: The social structure characteristic in the predisposing factor is defined by the education, occupation, family size and religion of clients. These attributes will be clarified below.

- Education in this study refers to the educational level attained by a client in a Nigerian educational system. The educational level will cover the lowest level of educational degree (primary school) to the highest level of educational degree (post graduate degree) attained by a client.
- Occupation in this study refers to the type of employment or activity that is performed by a client for financial reward. Armstrong and Kotler (2005:151) indicate that the occupation of clients will determine their choice of health institution. This indicates that, clients that have an occupation that pays a low salary may not be able to pay for the health care service offered in the private health institution.
- Family size (nuclear family or extended family) in this study refers to the total number of persons that reside in the same house (Koukouli, Vlachonikolis & Philalithis, 2002:3).
- Religion in this study refers to a set of beliefs held by a group of people concerning spiritual existence. It involves devotional and ritual observance

and contains moral conducts that guides the behaviour of people. Religion in this study will be classified into Christian, Muslim and other indigenous beliefs (Harris, Edlund & Larson, 2006:395).

- Beliefs in this study relate to the beliefs or perception that clients hold about the private health institution in general. It also addresses clients' attitude towards the private health institutions (Armstrong & Kotler, 2005:159).
- Values in this study refer to clients' principles and judgment about how valuable and important health care service is to their life (Snowdon & Hussein, 2012:10). It is a learned process that is influenced by the society, family, social network, parents and religion. Therefore, a client value regarding the private health institution comes as a result of the clients' personal experience with the health care service received or experiences of family, teachers and people within their social network (Snowdon & Hussein, 2012:10).
- Attitudes in this study describe clients' favourable or unfavourable evaluation of the private health institutions in general. Attitudes describe clients' feelings of like or dislike towards the health care services provided in the private health institutions (Armstrong & Kotler, 2005:159).

➢ The enabling factor in the modified theoretical model is defined by the clients' personal income, access to insurance and family financial support. The enabling factor in the modified theoretical model is proposed as a significant influence in the clients' decision-making process regarding the utilisation of private health institution. The characteristics and attributes of the enabling factors are discussed below for reasons of clarity.

❖ Income refers to the cash received for an exchange of labour or services rendered in a period of time. Household income refers to the combination of income of the people within a household. Income is a major factor that is related to better health. World Health Organisation (2013) indicates that clients with higher income are better linked to healthy living as compared to the lower income clients. In this study, the access to health care service in a private health institution is influenced by the clients' financial capability to pay for the medical expenses of the private health institutions (USAID, 2008:13).

- ❖ Health insurance coverage under the enabling characteristics in this study refers to the payment of health care service aided by insurance companies to enable clients to have access to health care service in a private health institution (Onwujekwe *et al*., 2011:2).
- ❖ Family financial support in this study refers to financial assistance provided by a clients' family to enable the utilisation of health care service in private health institutions (Bakeera, Wamala, Galea, State, Peterson & Pariyo, 2009:2).

1.3.2 Mediating and dependent variables

The modified theoretical model in this study consists of the mediating variable and dependent variables. The modified theoretical model asserts that the mediating variable (consumer decision-making process) will influence the dependent variables (customer satisfaction and cognitive dissonance). The mediating and dependent variable will be discussed below.

The consumer decision-making process in the modified theoretical model refers to the process that is undertaken by clients in order to make choices on alternative health institutions to satisfy their need for wellness. It is a process that begins before, during and after the purchase of health care service. The consumer decision-making process consists of six stages, namely, problem opportunity recognition, search, evaluation of alternative health institution, purchase decision, purchase act and post purchase evaluation (Kurtz & Boone, 2010:156). The modified theoretical model asserts that the consumer decision-making process will influence clients' outcome (customer satisfaction and cognitive dissonance).

Customer (client) satisfaction in the modified theoretical model refers to the situation in which the purchase of health care service from the private health institutions meets or exceeds clients' expectation. In other words, it is an outcome of contentment experienced by clients for using the private health institutions (Armstrong & Kotler, 2005:162).

The modified theoretical model asserts that cognitive dissonance is influenced by the consumer decision-making process. Cognitive dissonance refers to the discomfort,

dissatisfaction or doubt experienced by clients after the utilisation of health care services from the private health institutions (Armstrong & Kotler, 2005:162).

Table 1.1 below provides a comprehensive view of the independent variables and attributes of the modified theoretical model relevant to this study.

Table 1.1: Variables influencing the consumer decision-making process

Predisposing Factors	
Independent Variables	**Attributes**
Demographics	• Age • Gender • Marital status
Social structure	• Education • Occupation • Family size • Religion
Beliefs	-
Enabling Factors	
• Personal income	
• Access to insurance coverage	
• Family financial support	

Source: Own construction.

Table 1.1 reveals the independent variables in this study namely, the predisposing factor and enabling factor. The independent variables are proposed as being responsible for influencing consumer's decision-making process regarding the use of private health institution.

Table 1.2 provides a description of the mediating variable and dependent variables that are relevant to this study. The mediating variable (consumer decision-making process) is proposed to be responsible in influencing customer satisfaction and cognitive dissonance.

Table 1.2: Consumer decision-making process influencing the dependent variables

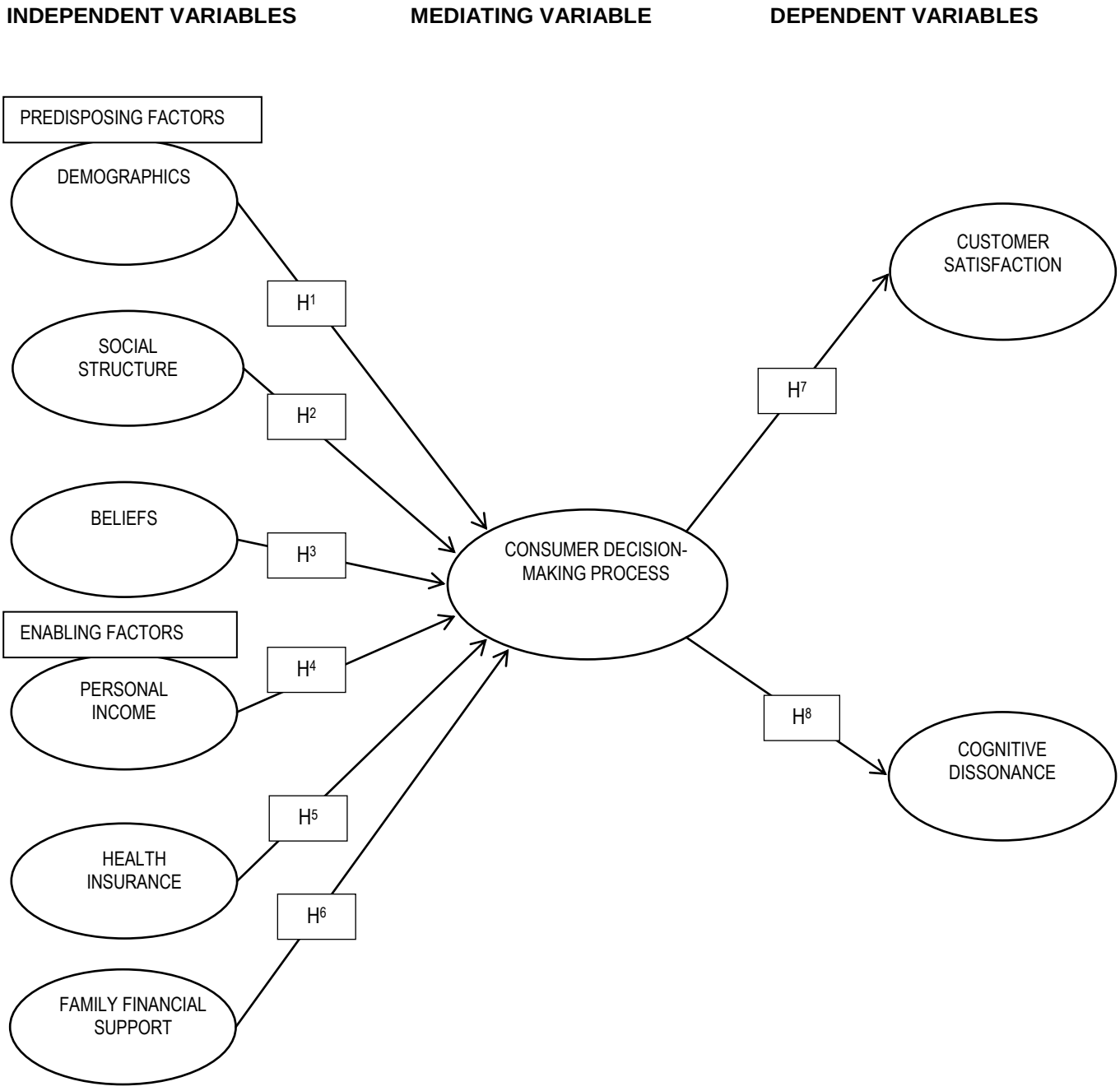
Mediating Variable	Attributes
Consumer decision-making Process	• Problem opportunity recognition • Search • Evaluation of alternatives • Purchase decision • Purchase act • Post purchase evaluation
Dependent Variables	
• Customer satisfaction	
• Cognitive dissonance	

Source: Own construction.

Given the summary of the variables and attributes in Table 1.1 and 1.2, it is therefore important to present the modified theoretical model for this research study. The modification is given in order to study the influencing factors in consumers' decision-making process regarding the use of private health institutions and the outcome of this process.

Figure 1.1 illustrates the theoretical model of factors influencing the consumers' decision-making process regarding the use of private health institutions.

Figure 1.1: Modified theoretical model of factors influencing the consumer decision-making process regarding private health institutions



The modified theoretical model shown in Figure 1.1 consists of the independent, mediating and dependent variables. In a general sense, the study asserts that the independent variables (predisposing and enabling factors) influence the mediating variable (consumer decision-making process), and that the mediating variable is

associated with the dependent variables that the study depicts as customer satisfaction and cognitive dissonance.

Taking a more specific viewpoint, the study proposed that demographic factors exert influence on consumer decision-making process. This presumption indicates that factors such as age, gender, and marital status have significant influence on the decision-making process of clients. Social structure and beliefs are also key predisposing characteristics which determine the consumer (client) decision-making process. In relation to this, the modified theoretical model puts forward that attributes such as education, occupation, religion, family size and clients' beliefs significantly influence the consumer decision-making process.

The enabling factors in the modified theoretical model affirms that personal income, access to health insurance and family financial support are capable of influencing the consumer (client) decision-making process. The modified theoretical model argues further that the decision-making process of clients is associated with the satisfaction that they derive from their choice of a private health institution. In a similar vein, the model posits that the decision-making process of clients is related to cognitive dissonance that may arise from choosing the private health institutions.

1.4 OBJECTIVES OF THE STUDY

Given the problem statement, it is pertinent to provide the objectives of the study through which the research problem will be resolved.

1.4.1 Primary objective

The primary objective of this study is to investigate the influencing factors on the consumer decision-making process regarding private health institutions. The rationale behind this study is to identify factors that influence the consumer decision-making process. The study will also assess whether the consumer decision-making process in the private health institution impacts on customer satisfaction and cognitive dissonance.

1.4.2 Secondary objectives

To achieve the primary objectives, the study has the following secondary objectives:

- to investigate literature on demographic characteristics, social structure, beliefs, personal income, health insurance as well as family financial support in the health institutions;
- to investigate literature on the health sector in general and in Nigeria;
- to develop a theoretical model based on the literature review to be empirically tested;
- to empirically investigate literature on customer satisfaction and cognitive dissonance regarding private health institutions;
- to analyse statistically the primary data gathered; and
- to provide recommendations for improving the health care services in the private health institutions.

1.5 RESEARCH QUESTIONS AND HYPOTHESES

This section will provide the guiding research questions and hypotheses formulated for this research study**.**

1.5.1 Research questions

Given the primary and secondary research objectives, the guiding research questions are presented below:

- How does demographic impact on clients' decision-making process in private health institutions?
- How do social structure and beliefs impact on the clients' decision-making process in private health institutions?
- How do personal income and health insurance impact on the clients' decision-making process in private health institutions?

- What is the impact of family financial support on the clients' decision-making process?
- What is the impact of decision-making process on customer satisfaction and cognitive dissonance?

1.5.2 Research hypotheses

The hypotheses formulated for this study is based on the modified theoretical model shown in Figure 1.1. The theoretical model provides the basis through which the primary objectives of this study will be achieved. The construction of the hypothesis is based on the independent variables (predisposing and enabling factors) and the dependent variables (customer satisfaction and cognitive dissonance). On the basis of the modified theoretical model, two sets of alternate hypotheses can be formulated. They are:

First set of alternate hypotheses: The influence of the independent variables on the consumer decision-making process regarding private health institutions.

H^1: There is a relationship between demographics and consumer decision-making process in private health institution.

H^2: There is a relationship between social structure and consumer decision-making process in private health institution.

H^3: There is a relationship between beliefs and consumer decision-making process in private health institution.

H^4: There is a relationship between personal income and consumer decision-making process in private health institution.

H^5: There is a relationship between access to health insurance and consumer decision-making process in private health institution.

H^6: There is a relationship between family financial support and consumer decision-making process in private health institution.

Second set of alternate hypotheses: The influence of consumer decision-making process regarding private health institutions on the dependent variables.

H^7: There is a relationship between the consumer decision-making process and customer satisfaction in private health institution.

H^8: There is a relationship between the consumer decision-making process and cognitive dissonance in private health institution.

1.6 OPERATIONALISATION OF THE RESEARCH VARIABLES

This section will provide detailed discussion on the concepts that is used in this study**.**

1.6.1 Consumer decision-making process

The clients' consumption of health care services are driven by the desire to satisfy unmet needs. Consumption is further motivated by the quest to improve social conditions. In addition, the consumption of health care service does not create satisfaction over a long period. As a consequence, clients demand more benefits than they purchase. In other words, clients require substantial satisfaction from their purchases and they tend to focus more on innovative and distinctive services (Voinea & Filip, 2011:15).

The quest to search for an innovative and distinctive health care service has caused dramatic and radical changes in consumer (client) behaviour. The behaviour of consumers is related to how they make decisions along several stages before they make a purchase (Verbeke, 2000:524). This change in consumer behaviour has caused a shift in the consumer decision-making process due to the availability of

several sources of information and various health institutions they can choose from (Torres & Guo, 2004:335).

The development that has taken place in the health care sector includes all factors that have also brought changes in the consumer decision-making process regarding the private health institutions. In Nigeria, the development is evident in the delivery of the health care services (intangible) associated with the tangibles (equipments) by private health institutions. This indicates that the private health institutions deliver quality health care service by using efficient and quality medical equipment (Okohue, Onuh, Akaba, Shaibu, Wada & Ikimalo, 2009:26). Other developments include the introduction of third-party payers (insurance companies, corporate companies, and government), availability of information on the internet, the growing awareness among clients to perform an extensive search before the purchase of health care service and the increased expectation from health care quality by clients and their family. The traditional form of offering health care service has advanced to a higher level of professionalism (Prakash, 2010:1). Due to the level of professionalism displayed by the private health institutions numerous Nigerians are propelled to make favourable decisions based on the utilisation of their health care service (USAID, 2008:16).

The consumer decision-making process can then be referred to as the stages that clients pass through knowingly or unknowingly to resolve an identified need. These stages are the problem/need recognition, search, evaluation of alternatives, purchase decision, purchase act and post purchase evaluation (Kurtz & Boone, 2010:153). In the health care setting, the decision-making process is the process that clients pass through in making choices on alternative health institutions (Shayo, Norheim, Mboera, Byskov, Maluka, Kamuzora & Blystad, 2012:2). Strydom *et al*. (2000:71) indicate that studying the consumer decision-making process will assist health institutions to create effective marketing activities that will focus on the needs of present and potential clients. This indicates that, an in-depth understanding of how clients choose and purchase health care services will provide information about the strategies that would help retain existing clients and attract new clients, thus making the health institutions successful (Cant, Heerden & Ngambi, 2010:50).

1.6.2 Cognitive dissonance

Cognitive dissonance is a feeling of doubt, discomfort, unhappiness or dissatisfaction that a client expresses after the purchase of a health care service. In other words, it is a client's feeling of doubt that the wrong choice of health institution has been made or the money spent on the health care service is not worth the health care service received. Therefore, cognitive dissonance is an imbalance between clients' knowledge and attitudes (Kurtz & Boone, 2010:156). Furthermore, clients that experience cognitive dissonance about the health care service they received respond irrationally. A client that is dissatisfied with the health care service of a private health institution may leave without stating the problem encountered and thereafter spread the dissatisfaction by negative word-of-mouth. At this point, a client's eagerness to change a health institution is based on the sufficient feeling of unhappiness about the outcome of the health care service received. Therefore, it is important that health institutions devise a strategy that consistently measures customer satisfaction and also sets up a system that gives confidence to clients to complain about dissatisfaction (Armstrong & Kotler, 2005:163).

1.6.3 Customer satisfaction

Customer satisfaction refers to the happiness that clients express over the purchase of health care service. Customer satisfaction can also be described as the situation in which the overall service performance exceeds the client's expectations (Armstrong & Kotler, 2005:162). Customer satisfaction has become a topic of discourse for most researchers in order to assess the quality and effectiveness of health care service rendered by health institutions (Lin, 1996:207). According to Prakash (2010:1), client satisfaction is an outcome portrayed by clients. Health institutions use this outcome as an indicator to measure the quality of health care service that they provide. Prakash (2010:1) further indicates that client satisfaction has become the principal aim for many health institutions because of the following reasons:

- it leads to client loyalty;

- they are less vulnerable to price wars;
- it creates room for consistent profitability due to clients retained and clients attracted; and
- it increases personal and professional satisfaction, that is, client satisfaction results in the health care providers' satisfaction.

Since client satisfaction is an indicator for making changes and improvement, it is crucial that private health institutions concentrate on improving the quality of health care service (Torres & Guo, 2004:336). In other words, to ensure client satisfaction, private health institutions have to formulate a clear distinction between the health care service and quality health care service. The health care service (contemplated, expected or received) differs from the perceptions of quality health care service (contemplated, expected or perceived as received) (Groth & Dye, 1999:338).

1.6.4 Dimensions of service quality

Service quality refers to the clients' overall impression of the relative inferiority/superiority of the health institution and its health care service (Bitner & Hubbert, 1994:77). According to Kang (2006:38), service quality is the clients' total judgment of the private health institution's achievement and superiority in delivering health care services. In order to deliver quality in health care service and to remain competitive, many health institutions have concerned themselves with learning more about what determines service quality and how they can effectively deliver it to clients (Chowdhary & Prakash, 2007:493). According to Groth and Dye (1999:337), health institutions that concentrate on enhancing clients' perceived value and service quality delivery, delivers extra value to clients, which, in turn, gives the health institution a competitive edge. Therefore, all dimensions of service quality perceived by clients result in their satisfaction (Kang & James, 2004:269).

Grönroos (2001:150) suggests that service quality in the health care sector has two dimensions which are the technical and functional quality. Technical quality in the health care environment refers to the professionalism, technical precision of diagnoses and procedures by the health care providers. Functional quality refers to

the process and manner in which the health care service is delivered to clients (Narang, 2010:171). However, for health institutions to remain successful and satisfactory to clients, the two dimensions of quality have to be managed and monitored effectively (Babakus & Mangold, 1992:768). Parasuraman, Zeithaml and Berry (1985) developed a model for measuring service quality (SERVQUAL). The SERVQUAL model conceptualises the perception of service quality as a gap between expected level of service and actual service performance. The objective of the model was developed to measure service quality as perceived by clients. SERVQUAL model was identified to have ten determinants in 1985 which was reduced to five determinants in 1988. The following are the five dimensions of SERVQUAL:

- **Reliability**: The ability of the health institution to keep to its promise in terms of superior service performance.
- **Assurance**: The health care provider and its staff can be relied upon by clients. Clients' degree of trust and confidence in the health care provider and employees.
- **Tangibles**: Tangibles represent the physical appearance of the service provider's environment, the appearance of the employees, user-friendly equipment and communication materials.
- **Empathy**: The ability of the health care provider and its staff to provide care and attention to its clients.
- **Responsiveness**: This relates to the readiness and ability of health care provider and its staff to provide quick and uninterrupted service to clients.

Therefore, to get clients satisfied the private health institutions has to understand and focus on improving the client's perceived quality and reducing the level of perceived risk in health care services (Palmer & Cole, 1995:17). Furthermore, Prakash (2010) suggests that to improve client satisfaction, health care providers should consider the following:

- make eye contact, smile, call clients by name and express words of concern;

- show courtesy by making kind gestures and using polite words that make the client very comfortable;
- encourage clients to ask questions and listen to their problems;
- pay undivided attention to the client;
- secure clients' confidentiality and privacy;
- extend empathy to the clients' family as a result of anxiety over the client; and
- keep appointments and apologise for delays.

1.6.5 Factors influencing consumer decision-making process

Decisions are made by people around the world everyday regarding the purchase of health care service. However, the final purchasing decision made by a client on a specific health institution is based on the decision-making process and factors that affect the decision-making process (Dietrich, 2010:1).

A plethora of researches has been conducted in a bid to identify factors that influence clients' decision-making process (Galloway, 1999:360). According to Schiffman and Kanuk (2004:9), the factors that influence clients' decision-making process are those factors that determine how clients search for quality in health care service, how they perceive and evaluate the health care service rendered to them, where they prefer these services and how often they require them. Kurtz and Boone (2010:135) state that the factors that influence the decision-making process of clients are external and internal. They reveal that factors such as cultural, social, family influence and personal factors will influence how clients make decisions regarding a health institution. In similar vein, Armstrong and Kotler (2005:144) postulate that when clients make decisions, a number of factors can affect the process they follow and those factors affect the decision they make. They state that cultural, social, personal and psychological attributes are the major factors that influence a client's decision-making process regarding the private health institution.

Furthermore, Andersen and Newman (2005:14) stipulate that the factors that influence the clients' decision-making regarding the use of private health institution

will depend on the predisposing factors, enabling factors and illness level. According to Gochman (1997:156), the predisposing and enabling factors were referred to as a predictor that will explain how clients make favourable decision regarding the utilisation of private health institution. The predisposing and enabling factors that influence clients' decision-making process regarding private health institution will be discussed below:

1.6.5.1 Predisposing factors

The predisposing factor is one of the factors that influence clients' decision-making process regarding the private health institution. The predisposing factor indicates that the propensity to make use of private health institution depends on the clients' demographics (age, gender, marital status), social structure (education, occupation, family size, religion) and beliefs (value concerning health, and attitudes towards health) (Chakraborty *et al*., 2003:328; Gochman, 1997:155). The characteristics under the predisposing factor will be discussed below.

Demographics in this study relates to clients' age, gender, and marital status. The demographics characteristics under the predisposing factor will influence the clients' decision-making process regarding private health institutions (Pappa & Niakas, 2006:8). According to Abor, Abekah-Nkrumah, Sakyi, Adjasi and Abor (2011:630), the demographic characteristics of clients are an important indicator for the analysis of clients' utilisation of health care service. Their findings reveal that, demographics such as age and gender determine a clients' utilisation of health care service. In other words, women (older women) are more inclined to make decisions regarding the utilisation of health care service more than the male. In similar vein, Chakraborty *et al*. (2003:328) affirm that the advancement of educational opportunities for women in recent years has given younger women an enhanced knowledge of health care service and modern medicine. Due to this advancement in knowledge, Mekonnen and Mekonnen (2002:7) and Fosu (1994) found that women are inclined to make decision on the utilisation of private health institutions.

Social structure such as clients' education, occupation, family size and religion are influencing factors regarding the decision-making process of clients. The type of

occupation that one has will affect one's decision-making process regarding the use of private health institution. According to Ibor, Anjorin, Ita, Otu, and Bassey, (2011:279), the occupation and the level of position of a client at a place of work has an influence on the decision-making process regarding the utilisation of private health institutions. In other words, a skilled worker with a top position takes care to select what is best for their health. Therefore, it is possible that a manager would prefer the health care service of a private health institutions and a trader in an open market is disposed to decide on the utilisation of public health institutions.

Furthermore, clients' decision-making process is influenced by the clients' family size. According to Armstrong and Kotler (2005:149), the family is the most decisive factor that influences the decision-making process of clients. A larger family size may cause resource shortage and therefore limit a client's use of a private health institution and encourage the use of the free health care service offered by the public health institution (Abor *et al*., 2011:631). Social class influences the decision-making process of clients regarding private health institution. Borrell, Fernandez, Schiaffino, Benach, Rajmil, Villalbi and Segura (2001:117) argue that the decision to utilise private health institutions will be a disadvantage to the lower class due to the cost involved in purchasing it. The research conducted by USAID (2008:16) shows that the Nigerian private health institutions provide the best health care service that is only afforded by the upper-income group. Due to this, the lower income group may be forced to make decisions regarding the health care service provided by the public health institutions.

Beliefs have a great influence on clients' decision-making process regarding private health institutions. The thoughts that clients hold about health care services are referred to as beliefs. The clients' beliefs shape their perception of health care services. Armstrong and Kotler (2005:159) explain that the beliefs that clients have about health care services is a result of their knowledge, opinion and faith, which may or may not carry an emotional charge. This knowledge, opinion or faith influences clients' decision-making process regarding utilisation of private health institutions. A client's choice to accept or reject a service is a result of its attitude towards it. In Nigeria, there are different cultural groups with different belief system with regards to health care service. These perceptions and belief systems that exist

in this cultural group include wellness/illness paradigms, diseases and disorders specific to certain culture, feelings about local health care providers and seeking health care services abroad, the use of long-established and native health care practises (Vaughn, Jacquez & Baker, 2009:65).

The beliefs, regarding health care service, in the northern part of Nigeria are grave. There are strong cultural beliefs and practises against the use of health care service during childbirth and maternity. These beliefs that tend to be against health care service have increased the mortality rate and maternal morbidity as compared to the southern region of Nigeria (Doctor, Bairagi, Findley, Helleringer & Dahiru, 2011:11). Numerous clients in Nigeria hold the belief that the public health institutions have better medical equipment and can provide better and professional health care service than the private health institutions. Clients in the rural areas also believe that consulting a deity or traditional healing is fast and effective for healing all kinds of diseases and resort to the use of it (Hanson, Goodman, Lines, Meek, Bradley & Mills, 2004:6). Beliefs and traditional values that large families are in favour of, religious scrutiny against contraceptives/birth control in the northern Nigeria, high levels of ignorance about health care service and medicine influence the decision-making process regarding utilisation of private health institutions (USAID, 2008:7). In this regard, beliefs affect the decision-making process of clients regarding the private health institutions in Nigeria.

1.6.5.2 Enabling factors

The enabling factors in this study refer to clients' personal income, access to insurance coverage and family financial support. The availability of the enabling factors allows clients to make favourable decision regarding the utilisation of private health institutions. In other words, the absence of the enabling factors, such as, personal income, insurance coverage and family financial support will automatically influence a clients' decision-making process regarding the utilisation of private health institutions (Willis, Glaser & Price, 2010). In a Nigerian health setting, the private health institutions operate on a "pay before service" or a "no credit today come tomorrow" (USAID 2008:13). Therefore, the decision to make use of the private health institutions will be based on clients' ability to have sufficient personal income

to pay medical expenses, insurance coverage (applies to clients that are covered) and afford assistance from family members (Andersen & Newman, 2005:14).

1.7 RESEARCH DESIGN AND METHODOLOGY

This section will provide a brief discussion of the design and methodology that will be used in this study.

1.7.1 Research design

In conducting a research study, various aspects have to be considered. The most vital aspect that is to be considered is a design that can be employed to carry out the research study. The research design represents the structure for conducting the research study (Hair, Bush & Ortinau, 2003:40). According to Hair *et al*. (2003:40), the research design assists the researcher to make further plans on the methods and procedures that will be used in gathering and analysing data. Furthermore, in drafting a research design the researcher should put into account the type of data that is to be collected, the design technique, the sampling procedures and the time scheduled for the research study.

1.7.2 Paradigm of the research study

In conducting a research study, it is important that the researcher decide on the research topic and paradigm that will be used for the study. The paradigm refers to the framework of beliefs, values and methods that give a clear guidance within which the research takes place (Willis, 2007:8). Basically, there are three types of methods that can be used in a research study. They are the qualitative, quantitative and mixed methods (Argyrous, 2011:20).

The qualitative research method involves fieldwork and the use of a small sample size to provide insights into the research problem. The method focuses on exploratory research designs (Cant, Gerber-Nel, Nel & Kotze, 2005:88). In a qualitative research, questions are asked or behaviours are observed in order to collect data. The qualitative research has the advantage of collecting data within a

short period of time. The qualitative research is beneficial in developing reliable and valid scale measurements for investigating specific consumer qualities. Therefore, in achieving a reliable and valid scale the qualitative research method will only be employed in pre-testing (pilot study) the measuring instrument in this study. A pilot study is a means of collecting primary data in a non-rigorous standard for a small scale exploratory research method that uses sampling (Cant *et al*., 2005:32). This approach will help discover and correct mistakes in the measuring instrument and also provide necessary feedback from clients (Hair *et al*., 2003:213).

The mixed methods is a method of research that addresses research issues or investigation by utilising both qualitative and quantitative research methods. In other words, the mixed methods research as triangulation of methods adopts or combines the qualitative and quantitative research methods in solving research problems (Johnson & Onwuegbuzie, 2004:14).

The quantitative research method attempts to quantify data and generalize results from a sample size selected from the population of research interest. This method of research employs the use of a statistical analysis means in analysing data (Cant *et al*., 2005:88). The quantitative research method focuses on the use of descriptive and causal designs. Measuring instruments such as the questionnaire, surveys and experiments are used to collect data from a large sample size in a quantitative research method. This entire study will make use of the quantitative research method. According to Hair *et al*. (2003:212), the quantitative research method is used in this study because of the following reasons:

- it allows the researcher to study the relationship that exists between the independent and dependent variables;
- it allows the researcher to test hypotheses and gain more insight into the relationship between variables; and
- it allows the researcher to be objective about the empirical findings of the research study.

The entire study was carried out by using the quantitative research method. In quantitative research method, the secondary research and the primary research was used to achieve the purpose of this study. As the secondary research deals with the gathering of existing data in a faster and less expensive way (Cant *et al*., 2005:66), in this study, a comprehensive literature was conducted by consulting secondary sources. The secondary sources employed in this research study were gathered from international and national sources through the Nelson Mandela Metropolitan University from journal articles, newspapers, text books and reliable websites. The secondary sources provided useful information from previous studies on the factors that influence consumer decision-making process in general and in the Nigerian health system, customer satisfaction and cognitive dissonance.

The primary research refers to the use of experiments, investigation, observations, surveys and tests in collecting first hand primary data from respondents to address an identified research problem (Cant *et al.*, 2005:87). The primary research is often based on a scientific method that allows researchers to explore and have an in-depth knowledge of scientific enquiry (Driscoll, 2011:154). In this study, the primary research was conducted by gathering primary data by means of a survey. Survey refers to the collection of primary data by means of a measuring instrument (questionnaire) that is distributed to respondents (Driscoll, 2011:154). Primary data collected by means of the measuring instrument was analysed to provide information for resolving research problems.

1.7.3 Population and sampling

In order to gather accurate and useful data, population and sample frame that will be used in a research study have to be defined based on the nature of the study. The target population refers to the entire universe to which the study is directed in resolving the research problems (Lehmann, Gupta & Steckel, 1998:284). The population of this research study refers to clients that utilise the private health institutions in Lagos state, Nigeria. Furthermore, the sample size is drawn from the targeted population. The sample in this research study was drawn by means of a non-probability sampling technique: convenience sampling and snowball sampling. Convenience sampling technique involves selecting respondents that are available

by chance. In other words, questionnaires are deployed to respondents that are readily available. Convenience sampling method enables the researcher to draw its sample size in a convenient way with little or no cost (Cant *et al*., 2005:164). In snowball sampling technique, the respondents assist the researcher by providing other respondents within the target population. The snowball sampling technique continues as the respondents introduce the researcher to other respondents within the sample frame. The sample size drawn for this research study was 450 clients utilising the private health institutions in Lagos state, Nigeria (Cant *et al*., 2005:164).

1.7.4 The research instrument

The questionnaire is a research instrument that is used in gathering primary data from respondents to resolve a research problem. The questionnaire is seen to be the most common type of measuring instrument used in a marketing study. Thus, this study employed the use of a questionnaire in gathering the primary data. The questionnaire was designed in three sections, namely, cover letter, Section A and Section B. The interval scale was used in section A which contained questions on a 5-point Likert, scale ranging from strongly disagree to strongly agree. Questions in section A measured demographics, social structure, personal income, beliefs, health insurance and family financial support regarding the utilisation of a private health institution. Section A also covered questions on customer satisfaction and cognitive dissonance. Section B contained biographical information of respondents. Section B employed the use of nominal scales and covered questions relating to respondents' gender, age, monthly income, marital status, family size, education, nature of field, occupation and religion (Cant *et al*., 2005:147).

Moreover, this study carried out the validity of the measuring instrument. Validity is the extent to which the research study measures what it is intended to measure (Cant *et al*., 2005:235). The validity of the measuring instrument is important for good measurement in a study. It is the key in assessing the authenticity of this study. The validity in this study enabled the researcher to avoid systematic or random errors by measuring the variable it intends to measure. The research instrument used in this study was evaluated by means of a content and construct validity. The content validity assessed the items in the questionnaire and ensured that the

questionnaire measured the characteristics that are intended to be measured (Barry, Chaney, Piazza-Gardner & Chavarria, 2014:13). The construct validity also ensured the correctness in the measurement of the theoretical construct of the study (Wilson, 2010:120).

Reliability in this study refers to the extent to which the measuring instrument (questionnaire) or the measuring procedure produces consistent results if repeated continuously on the research concepts (Roberts & Priest, 2006:41). Roberts and Priest (2006:42) state that reliability measures are scores that can be seen as proportions that tells the correctness of the measures of the research instrument. In this case, a score of 0.85, for instance, indicates that a research instrument has, to the extent of 85%, correctly measured a particular concept and 15% is accounted for as the random error. The method employed in assessing the reliability of the research instrument in this study was the internal consistency reliability. The internal consistency reliability (Cronbach's alpha) provides a good estimate of reliability and the degree to which part of the scale is correlated. The cut-off point of Cronbach's alpha used in assessing the reliability of the measuring instrument in this study is 0.6 (Salkind, 2010:162).

1.7.5 Data collection

Data collection is crucial in order to gather information to resolve identified research problems and achieve set objectives in a research study. Data can be collected through secondary and primary sources. Primary and secondary data was collected to achieve the research objectives and proffer solutions to the research problem (Landy & Conte, 2007:55). Secondary data are pre-existing data. They are basically historical data that have been assembled by a researcher or various researchers for an identified problem relevant to their study. The advantage of secondary data is that it can be collected in alacrity with less cost. However, researchers must gather secondary data that is relevant to its study (Hair *et al*., 2003:100). In this study, secondary data was gathered by assessing journals, articles, government publications, text books, newspapers and reliable websites through the Nelson Mandela Metropolitan University library.

Primary data represents raw data that is gathered to achieve the objectives of the present research study (Lehmann *et al*., 1998:87). The primary data gathered is used to address a problem specific to a research study. It is also known as a first hand data that is to receive a meaningful interpretation (Hair *et al*., 2003:42). In this study, primary data was gathered by means of a structured questionnaire from respondents located in Lagos state, Nigeria. This method of collecting raw data was appropriate in this study because it allowed the researcher to gather sufficient amount of information from a large number of respondents in a short period of time with little cost.

1.7.6 Data analysis

The data collected by means of the questionnaire was statistically analysed using the Statistica package (Version 12). The data analysis was done in five stages. The first stage of analysis, an exploratory factor analysis (EFA) EFA was used to assess the variability of the items in the research instrument. The second stage assessed the reliability of the measuring instrument (Cronbach's alpha). The Cronbach's alpha used in assessing the reliability of the measuring instrument had a cut–off point of 0.6. The third stage analysed the primary data using descriptive statistics. Descriptive statistics reduced large amount of data into a summarised and sensible form using frequency tables (mean and standard deviation). The fourth stage progressed into an advanced method known as the multiple regression analysis. The multiple regression analysis described the relationship that exists between the independent and dependent variables. The fifth stage of analysis was correlation analysis (Pearson correlation). The correlation analysis studied the association between two variables and the coefficient of correlation described the strength of the association between two variables (Lind, Marchal & Wathen, 2006:377-422).

1.8 CLARIFICATION OF CONCEPTS

The concepts used in this study will be discussed below in order to clarify them.

Consumer decision-making process refers to the sequential stages that clients pass through in order to make purchase decisions (Kivetz & Simonson, 2000:427). In

the context of this study, consumer decision-making process refers to steps that clients pass through in order to purchase health care services from private health institutions.

Consumers/clients: Consumers in this study refers to people that purchase goods for use or consumption, whilst clients refer to people that purchase any type of services. Consumers/clients will be used interchangeably in this study. Clients in this study refer to people that purchase health care services from health institutions (Naik & Reddy, 1999:3).

Health care services are services delivered by health care providers for the purpose of promoting, maintaining or restoring health (World Health Organisation, 2004:68). In view of this study, health care services refer to the services rendered by the public and private health institutions for the purposes of ensuring wellness.

Health care sector/ Health institutions pertain to public health institutions and private health institutions. World Health Organisation (2004:68) provides a more elaborate definition by noting that the sector consists of organised public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related non-governmental organisations (NGOs), community groups and professional associations.

Private health institutions refer to health institutions owned by individuals or corporate bodies for the purpose of making profit. Private health institutions are independent health care providers that are not funded by the government.

Customer satisfaction is a measure of how well the health care service meets or exceeds clients' expectations. According to Anderson and Salisbury (2003:115-124), customer satisfaction points to the perceptions of clients overall consumption experiences of health care services. This study conceptualises customer satisfaction as the contentment clients have that the health care service delivered by the private health institution meets or exceeds their expectation.

Cognitive dissonance refers to the disappointment or doubt that clients experience after the purchase of health care services that did not meet or exceed its expectation (Kurtz & Boone, 2010:156).

1.9 PRIOR RESEARCH

Numerous researches have been conducted on factors influencing consumer decision-making process regarding the utilisation of health care service internationally and nationally. However, the study of factors influencing the consumer decision-making process regarding the use of health care institution in Nigeria focused on the public health institutions. A plethora of research has focused on the health care service provided by the three tiers of government and financial support by the government or mostly focused on the utilisation of health care service in the rural areas and the challenges faced by the public health institution. The research conducted by Olakunde (2012) focuses on the public health care service financing in the public health institution in Nigeria and how a sustainable financing of the health care system can improve the economy. Olakunde (2012:8) states that achieving health care financing is a major constraint in Nigeria because of insufficient financing and donations by the government, extensive use of personal income by clients to pay for medical expenses and limited health insurance coverage. Olakunde (2012:8) concludes that the government should invest in the health sector and strive to provide an affordable and accessable health care service to clients that can or cannot afford it. The Social Health Insurance (SHI) and Community-Based Health Insurance (CBHI) should also strive to cover as many clients in both the rural and urban areas.

Additionally, the study by Abdulraheem, Olapipo and Amodu (2012) identify critical issues in the primary health care services and provide strategies that will enhance the use of health care services in the rural areas in Nigeria. Despite the problems evident in the health sector in Nigeria, the findings reveal that clients in the rural areas under-utilised the basic health care services provided by the government. Therefore, Abdulraheem *et al*. (2012:12) conclude that a continuous dialogue and effective dissemination of information regarding the importance of health care should be done in the rural areas. Rural communities should be empowered through

orientation and training to enhance their utilisation of the primary health care service provided by the government.

In Nigeria, almost no specific research was carried out on the factors that influence clients' decision-making process regarding the private health institution and the outcome of the clients' purchase from the private health institution in Lagos state, Nigeria. In this regard, the use of prior research relevant to this study and this research study helped to bridge the gap in identifying the factors that influence clients to make a favourable decision regarding the utilisation of private health institutions. The research also discovered clients' outcome (customer satisfaction or cognitive dissonance) of the health care service received in the private health institutions. Resolving the research problems helped to provide useful information that was used in enhancing the quality of service delivered by the private health institutions in Nigeria.

1.10 DELIMITATION OF THE STUDY

The health care sector of the Nigerian economy comprises health care providers that are either governmental or privately owned. These health care providers are widely dispersed across the thirty states of Nigeria. Lagos State which is the most populated territory in Nigeria was the focal point for this study. In other words, the private health institutions located in Lagos state, Nigeria formed the purview of the study.

1.11 SIGNIFICANCE OF THE STUDY

The study expanded the current understanding of the influencing factors on the consumer decision-making process and it helped to establish a theoretical model for service delivery in private health institutions in Nigeria. The study created strategies of coping with financial constraints for the payment of medical expenses in the private health institutions in Nigeria. This study provided recommendations that assist the private health institutions and that enhance customer satisfaction and the effectiveness of health care service delivery in Nigeria.

1.12 STRUCTURE OF THE STUDY

The structure of the study presents in summary what the following chapters in the research study will be.

Chapter 1: Scope and Background to the study

This chapter will focus on the background of the study. It will present in detail the problem statement, the objectives and the formulated hypotheses for this research study.

Chapter 2: Overview of consumer decision-making

This chapter will provide a comprehensive literature review regarding consumer decision-making process in general and in the health sector. It will further discuss the factors that affect the consumers' decision-making process by highlighting various secondary sources. This chapter will further discuss the outcome (customer satisfaction and cognitive dissonance) of the consumer's decision-making process regarding the private health institutions.

Chapter 3: Health care sector in Nigeria

This chapter will discuss in detail the general overview of the health sector in Nigeria. Information regarding the structure of the health sector, the role of the government and other health regulatory bodies, benefits and challenges will be provided. It will further discuss the various types of health institution and provide a comparison between the private health institutions and public health institution in Nigeria. This chapter will also compare the private health institution and the public health institution.

Chapter 4: A model for consumer decision-making process of private health institutions

This chapter will provide discussion of the theoretical model and the modified theoretical model developed for this study.

Chapter 5: Research design and methodology

This chapter will highlight the methodology that is employed in this research study. It will provide a detailed discussion of the research design and methods, data collection, measuring instrument and data analysis.

Chapter 6: The empirical results of the clients' decision-making process regarding private health institutions

This chapter will focus on the analysis and interpretation of the primary data gathered from respondents.

Chapter 7: Summary, conclusions and recommendations

This chapter will provide a summary of the entire study. It will also provide recommendations that will be useful for the improvement of the private health institutions. The recommendations will be based on how the private health institutions can better understand the underlying factors that influence the decision-making process of clients and how they can improve their services to better satisfy and retain existing clients.

CHAPTER TWO
OVERVIEW OF CONSUMER DECISION-MAKING

2.1 INTRODUCTION

The decisions made by consumers relate to the purchase of goods and services to satisfy a need. The urge to satisfy this need has created a change in the way consumers behave in making decisions. The change in consumers' buying behaviour and purchase decisions are evident in the way in which clients conduct an intensive search for information on better quality and benefits before a purchase decision is made to satisfy their needs. Clients further enlighten themselves about the goods and services they seek to purchase by gathering more information from friends and family, social networks and the internet. The information sourced by clients is used to compare prices and quality of services offered by two or more companies before making purchase decisions appropriate to their needs (Voinea & Filip, 2011:15).

The needs and preferences of clients are exclusive, but they exhibit matching behaviour and follow similar decision-making processes in making choices about services to be purchased. Along the decision-making process, consumers are influenced by several factors that propel them to make purchases (Blythe, 2006:106). In order to remain in business and become profitable, many companies have conducted intensive research in order to understand the consumer decision-making process and the factors that influence clients' purchase decision. Furthermore, the research conducted by several companies is done to understand clients' wants and needs, how they search for information on services, select a company over other alternative companies and why they dispose and retain services (Kotler & Keller, 2011:188). This understanding of how these clients behave has forced many companies to focus their marketing activities and communication tools on retaining and attracting clients from different age categories and classes (Cant *et al*., 2010:64).

Despite the effort that companies exert in trying to attract, retain and understand the way clients make decisions, most clients still behave irrationally. This indicates that,

the final purchase decision that is made by consumers may differ from their ideal need at the problem recognition stage along the consumer decision-making process. The change in the purchase decisions is a result of the influence of certain factors, namely, the individual influences (motivation, perception, attitude, personality), situational influences (socio-cultural, technological, economic/competitive, political/legal), group influences (family, reference groups, social class, culture/subculture) and marketing mix (price, product, place, promotion) along the consumer decision-making process (Brassington & pettitt, 2003:93-94). Mullins *et al*. (2008:99) indicate that some of the influential factors include the consumers' social class, family situation, values, past experiences, attitudes and benefits sought. These factors have an impact on how clients make decisions on purchases, source for information before purchase, select from alternative companies, dispose and retain the use of such services purchased (Schiffman & Kanuk, 2004:9).

The objective of this chapter is to highlight extensive literature concerning the consumer decision-making process in general with specific reference to the health care sector. This chapter further discusses the types of purchase decisions, the steps taken in the consumer decision-making process and the buying process for service. The consumer involvement in purchasing service and the determinants of consumer involvement will also be discussed. Furthermore, the benefits and challenges of the consumer decision-making process will be highlighted.

2.2 TYPES OF PURCHASE DECISIONS

The decisions or actions exhibited by clients prior to the purchase and utilisation of goods and services are referred to as a purchase decision (Lamb, Hair & McDaniel, 2009:67). Clients make this decision to solve a need or an identified problem. In order to purchase goods and services to solve a need, clients follow the consumer decision-making process (Lamb *et al*., 2009:67). Although making purchase decisions requires a client to follow the consumer decision-making process, not all purchase decisions along the consumer decision-making process made by clients are treated equally (Strydom *et al*., 2000:72). This implies that the type of purchase decision made by the client depends on the buying situation, such as purchase of new or repeated goods or services. Clients employ the use of a complex buying

behaviour to solve the need associated with new purchase of goods and services. In an extensive decision-making, the information that is gathered by clients is new and not known. Therefore, clients encounter a high perceived risk and utilise a substantial amount of time and energy to make purchase decisions that exceed the time and energy spent when a purchase decision is made on repeated purchase of goods and services (Kasper, Van Helsdingen & Gabbott, 2006:102). Thus, for clients to make the right decision on expensive goods and services to be purchased for the first time, they extensively follow all the stages of the consumer decision-making process.

Additionally, Kurtz and Boone (2010:144) maintain that the decision to follow through all the stages in the consumer decision-making process or making an immediate purchase is a result of the clients' past experience, learning, attitude and perception of the goods and services to be purchased. Similarly, McDaniel, Lamb and Hair (2006:199) suggest that the clients' purchase decision is described in terms of five factors, namely, the level of consumer involvement, the length of time to make decisions, the cost of goods or services, the degree of information search and the number of service providers considered. Furthermore, the type of purchase decision that is made by clients to purchase goods and service varies, depending on the nature or the type of goods and services and the level of consumer involvement. Some purchase decisions can be complicated and may require an effort by the client or it may be regular and require less effort (Strydom *et al*., 2000:72). The types of purchase decision made on goods and services will be discussed for the purposes of clarity.

2.2.1 Routine decision-making

Furiji, Tatuszyńska and Wawrzyniak (2012:80) report that in a routine decision-making, consumers are regarded as brand loyal as goods or services are purchased without conscious effort. This indicates that, consumers and clients must have passed through the consumer decision-making process and are satisfied with the purchase decision made on an evaluated brand. Thereafter, when a consumer recognises a need, some stages in the consumer decision-making process (search and evaluation of alternatives) are not followed and the consumer makes a quick

purchase decisions. In other words, the routine decision-making minimizes the consumer decision-making process each time the goods or services are required (Furiji *et al*., 2012:80). According to McDaniel *et al*. (2006:199), routine decision-making is referred to as the routine response behaviour whereby clients purchase goods and services without effort on time and energy.

The purchase decisions made on goods and service associated with the routine response behaviour involves low consumer involvement, quick purchase decisions making, low cost and involved in the internal information search on products and services (McDaniel *et al*., 2006:199). This indicates that, clients spend little time and effort on search and evaluation before making a purchase decision. In this case, clients do not experience need recognition until they are faced with in-store or media advertisement from that brand. Clients have experience of the goods and services and often purchase goods and services quickly and perform evaluations later (McDaniel *et al*., 2006:199). Boshoff and Du Plessis (2009:61) reveal that routine decision-making occurs when a client repeatedly or consistently purchases services from the same service provider without conscious effort. Routine decision-making in the health care sector, for example, occurs when a client consistently goes for a routine treatment and check-up for self-maintenance from the same health care provider.

The brand loyalty is a result of the extensive consumer decision-making made in the past and the positive experience that has been encountered by the client. Thus, the client overtime has experienced wellness and satisfaction from the consistent check-ups and prescription and medical advise made by the health care provider. Therefore, each time the health care service is required, the routine decision-making reduces the clients' need to follow all the stages in the consumer decision-making (Boshoff & Du Plessis, 2009:61).

2.2.2 Complex buying behaviour

Furiji *et al*. (2012:80) assert that in goods and services that are rarely purchased and expensive, clients are highly involved in making purchase decisions and are conscious of the differences that exist amongst a variety of similar brands in a complex buying behaviour. The purchase decisions, for example, made on cars, houses, furnitures, personal computers and household appliances require a complex buying behaviour. Consumers often require assistance and information on the attributes and benefit that can be offered to them before they make a purchase decisions. McDaniel *et al*. (2006:199) refer to the complex buying behaviour as an extensive decision-making. McDaniel *et al*. (2006:199) assert that the information on the benefit and attributes of the goods or services given is a result of the perceived risk involved in the purchase.

Extensive decision-making occurs when the client intends to purchase new and unfamiliar services that are high in cost and have a great number of alternatives. Clients often take a longer time in making internal and external search for information and critical evaluation follows after the necessary information has been gathered (McDaniel *et al*., 2006:199). Additionally, the type of purchase decision that is made by clients, irrespective of the nature of goods and services, does not remain the same. This indicates that, when a client intends to make a switch from routinely purchased goods or services to goods and services that are new in the market or to be bought for the first time, the client employs a complex buying behaviour. This type of behaviour propels the client to pass extensively through all the stages of the consumer decision-making process in order to make the right decision (McDaniel *et al*., 2006:199).

Specifically on services, an extensive decision-making is carried out by a client when the service to be purchased is expensive, not bought frequently and there exist a high level of perceived risk. Extensive decision-making in the choice of health institutions occurs when the client seeks a health care provider or specialist that can perform a specific surgical operation. Surgical operations are performed infrequently and such a purchase requires an extensive search and a high involvement by the client (Blythe, 2006:109).

2.2.3 Limited decision-making

Furiji *et al*. (2012:80) stipulate that when consumers deem that minimal differences exist amongst variety of similar brands, they are likely to be involved in a limited decision-making. Therefore, consumers take their time to look at several available brands that are in the market and often make a purchase decision fairly quickly. According to Furiji *et al*. (2012:80), the limited decision-making is a combination of the extensive purchase decision and the routine purchase decision that requires a moderate amount of time for information gathering and deliberation.

According to Mullins *et al*. (2008:99), in a limited decision-making client perform an extended search for information in consideration of alternative goods and services. Clients are familiar with the availability of alternative goods and services but lack adequate information on the feature of the brands and also have no brand preference. Therefore, to make a purchase decision, the amount of time and energy that are put in by the client in the search and evaluation of alternatives and the consumer decision-making process are neither low nor high but moderate. The clients' purchase of a medical aid cover is an example of a limited decision-making in health care (McDaniel *et al*., 2006:199).

2.2.4 Impulsive decision-making

Mohan, Sivakumaran and Sharma (2013:1713) refer to impulsive decision-making as an unplanned or hasty purchase decision made by a consumer. In other words, it is an unplanned action that consumers make at the point of purchase. Consumers make this hasty purchase decision after all the stages in the consumer decision-making process have been completed. This indicates that purchase decision is quickly reached when the need is deemed important and has to be resolved urgently. Purchase decisions made by consumers happen immediately once the need is recognised by the consumer. According to Verhagen and Van Dolen (2009:4), impulsive decision-making occurs immediately and this immediate purchase can be triggered by an in-store product display or sales promotion encountered by the client. A client, for example, who always had the need to check its sugar level goes to visit a friend in the hospital and is asked to wait for one hour.

The free advertisement or promotion for checkup on sugar level in the hospital might compel the individual to make a hasty decision, within the blink of an eye, to satisfy its need. This unplanned action at the point of purchase is regarded as a responsible approach of purchasing services because the client to some extent progresses through all stages of the consumer decision-making progress and action follows after the decision to purchase has been reached (Boshoff & Du Plessis, 2009:61).

2.2.5 Habitual buying behaviour

According to Rauyruen and Miller (2009:176), habitual buying behaviour occurs when there is little or no brand difference amongst variety of similar service brands or goods and consumers repeatedly make purchase of goods and services to save time, money and disappointment. According to Nayeem and Casidy (2013:735), consumers frequently make purchase of these low-priced goods and services and they are not brand loyal especially when prices of goods and services are low or another brand is offering sales promotion. Furthermore, habitual buying behaviour might also occur when clients purchase services from service providers that exceed their expectations in quality. The satisfaction that the client derives from the services performed, often results in their loyalty but, because clients buy out of habit, they might not patronise the service provider for a long time. Habitual buying behaviour in services, for example, is in the choice of dentist, opticians and hair salons (Boshoff & Du Plessis, 2009:61).

2.2.6 Variety-seeking buying behaviour

Mullins *et al*. (2008:107) suggest that the variety-seeking buying behaviour occurs when significant differences exist amongst variety of similar service brands and clients are less involved in making purchase decisions. Although, clients show satisfaction with their present brand, they are not brand loyal. Clients often switch to other similar services (alternatives) that offer variety of services. Thus, variety-seeking behaviour occurs when a client gets bored with the offerings of the current service brand and seeks to try out new alternatives. Therefore, variety-seeking buying behaviour is identified as a determinant factor for brand switching. Although, variety-seeking behaviour is related to a low consumer involvement, it usually implies

some degree of risk taking on the part of the consumer. This indicates that clients fear the functional risk that the new service brand may not adequately satisfy its need (Van Trijp, Hoyer & Inman, 1996:283).

2.3 CONSUMER DECISION-MAKING PROCESS

The consumer decision-making process refers to a problem-solving process that consumers go through before, during and after a purchase decision. Consumers (clients) may not be aware of it but it is a process that they pass through in order to satisfy a need (Kurtz & Boone, 2010:153). Similarly, McDaniel *et al*. (2006:191) state that the consumer decision-making process is a five-step process that is used by clients in purchasing goods and services. According to Kotler and Keller (2011:188), the five stages of the consumer decision-making process include the problem recognition, information search, evaluation of alternatives, purchase decision and post-purchase behaviour.

Clients pass through a similar consumer decision-making process to make purchase decisions on goods and services. However, the decisions that are made by clients to purchase goods and services are different as a result of the clients' personal characteristics such as, the needs, benefits, attitudes, past experience, lifestyle and also the social influences such as the clients' social class, reference groups and family (Mullins *et al*., 2008:98).

Moreover, purchase decisions made on goods and services means that the client will pass through a process prior to purchase. However, the process of decision-making differs for both goods and services. This implies that goods and services share similar stages from the awareness of needs/problem recognition to the evaluation of alternatives and afterwards there is a difference between the consumer decision-making process and buying process for services (Lovelock & Wright, 2002:88). After the evaluation of alternative stage in the buying process for services, the client progresses into the request of service from chosen supplier stage, service delivery stage, evaluation of service performance stage and the future intentions stage (Boshoff & Du Plessis, 2009:63). Whilst in consumer decision-making process,

consumers progress from the first three stages to purchase decision, purchase act and post-purchase evaluation (Kurtz & Boone, 2010:153). The purchase decision process for this study refers to the stages that consumers/clients go through in purchasing goods or services. The decision-making process for both goods and services will be discussed expansively.

2.3.1 Determinants of the consumer decision-making process

The determinants of the consumer decision-making process are factors that influence a consumer purchase decisions and buying behaviour (Furiji *et al*., 2012:78). According to Furiji *et al*. (2012:78), these factors that influence the consumer purchase decisions are classified into five groups, namely, cultural factors, social factors, physical factors, personal factors and marketing mix. Figure 2.1 as depicted by Hoffman *et al*. (2005:177) illustrate the factors that influence the clients' decision-making process regarding the utilisation of private health institutions. These factors are psychological factors, social factors, situational factors and technological factors. Armstrong and Kotler (2005:144) argue that factors, such as, cultural (culture, subculture and social class), social (reference groups, family, roles and status), personal (age and life cycle stage, occupation, economic situation, lifestyle, personality and self-concept) and psychological (motivation, perception, learning, beliefs and attitudes) are major determinants of the consumer decision-making process. Armstrong and Kotler (2005:144) state that these factors influence the consumer decision-making process and are responsible for the reason why clients will make a purchase decision regarding the choice of a health institution. Additionally, Kurtz and Boone (2010:151) argue that factors, such as, interpersonal determinants (cultural influences, social influences and family influences) and personal determinants (needs and motives, perceptions, attitudes, learning and self concept) will influence a client's decision to purchase health care services.

Furthermore, Juliusson, Karlsson, and Garling (2005:562) stipulate that a client's past experience is also capable of influencing its decision-making process regarding the use of a private health institution. This indicates that the past experience (good or bad) of a client regarding the use of a health institution will result in either the

continuous use or rejection of the health care service. Additionally, Andersen and Newman (2005:14) argue that the enabling factors (income, access to financial coverage, family financial support) and predisposing factors such as a clients demographics (age, gender, marital status), social structure (education, occupation, family size, religion), and health beliefs (values, attributes) are the factors that influence clients' decision regarding the utilisation of health care services.

2.3.2 Steps in the consumer decision-making process

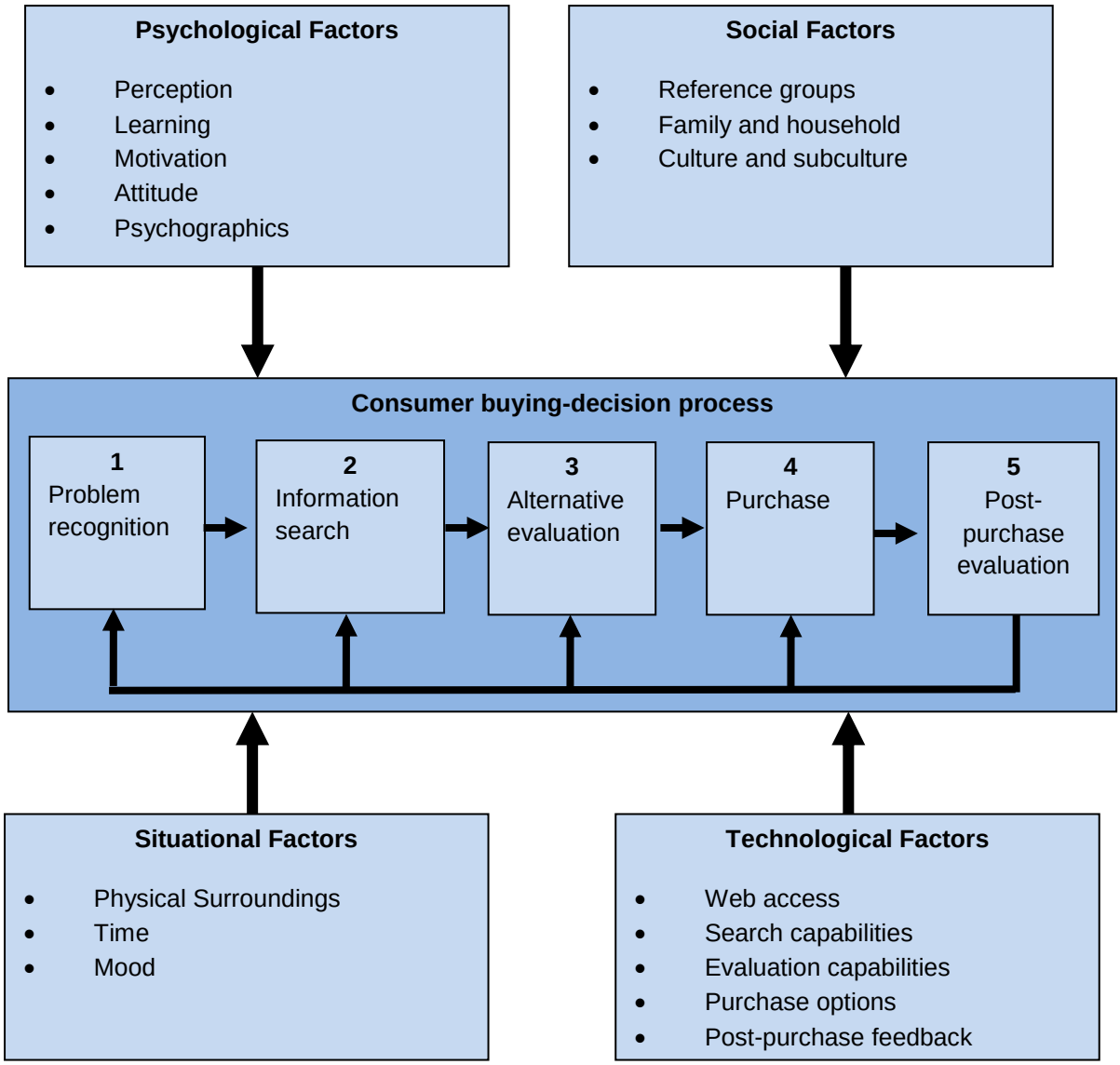
Research on how clients make choices and the steps they go through in the consumer decision-making process reveals important insights for health institutions. Understanding the process clients go through in purchasing health care services can help health institutions understand the needs of clients and to offer quality health care services to satisfy their need. The steps in the consumer decision-making process reveal how clients purchase health care services to solve their need for wellness. All clients follow similar consumer decision-making process in satisfying their need for wellness. In contrast to this, most steps in the consumer decision-making process (search and evaluation) are not followed by loyal clients (Hoffman *et al*., 2005:176).

Figure 2.1 illustrates the consumer buying-decision process as depicted by Hoffman *et al*. (2005:177). The model reveals five steps that clients take in a decision-making process. The first step in the decision-making process is problem recognition of an unmet need. Clients, at this stage, have identified a need/problem associated with their well-being. In other words, the client becomes aware of a need for wellness. The second step involves how the client searches for information about a suitable health institution required in resolving its need for wellness. Figure 2.1 shows that the client's third step involves the evaluation of alternatives. This is the stage where a client makes use of information gathered to evaluate a few selected health institutions. Alternatives in the health institution in Nigeria can either be a choice between the public health institution and private health institution or a choice between two different private health institutions.

Furthermore, the fourth step in the consumer decision-making process is the purchase act. Kurtz and Boone (2010:155) state that at these stages clients evaluate the selected alternatives and make a decision about where or from whom to make its purchase. Finally the client purchases health care services from the most preferred health institution to resolve its need for wellness. Figure 2.1 also illustrates the final stage that a client passes through in the consumer decision-making process. This stage is the post-purchase evaluation that reveals if the client is either satisfied (purchase meets or exceeds expectation) or dissatisfied (purchase does not meet or exceed expectation) with the purchase of the health care service from the selected health institutions (Hoffman *et al*., 2005:184). Clients experience cognitive dissonance when they are not happy with the overall quality of health care services delivered to them. In other words, clients may experience discomfort or doubt the health care service received from the selected health institution. The outcome of cognitive dissonance may lead to the rejection or continuation of the use of the health care service from the health institution selected (Kurtz & Boone, 2010:156).

Figure 2.1 illustrates the consumer buying-process as depicted by Hoffman *et al*. (2005:177).

Figure 2.1: Consumer buying-decision process



Source: Hoffman *et al*., 2005:177.

The stages in the consumer decision-making process are discussed for purposes of clarity.

2.3.2.1 Problem recognition

The problem recognition stage is the first stage that a client passes through in the consumer decision-making process regarding the utilisation of health care services. This is a stage where a client recognises the need for wellness (Metrosa, 2006:165). According to Strydom *et al*. (2000:74), clients realise that there is a difference

between a desired state of affairs and the actual state of affairs when a need or problem is identified. Furthermore, the Agency for Healthcare Research and Quality (1996:1) asserts that the early recognition for the need of health care service can prevent a clients' untimely death. In other words, the early recognition of health care need can help to detect ailments and prevent untimely death. As a result of early recognition, timely treatments can be given to ailment that can be treated and if it is not treatable it will help the client and family prepare financially and mentally in advance.

2.3.2.2 Information search

The second stage in the consumer decision-making process is the information search stage. After a client recognises that there is a difference between a desired state of affairs and the actual state of affairs they begin to search for information regarding the health institution that provides quality health care service and range of benefits to meet their wellness (Blythe, 2006:109). The research findings by Tu and Cohen (2008:1) reveal a rising percentage in the number of clients that search for health information regarding the use of health institutions. The research findings further indicate that, clients that actively searched for health information showed a positive attitude towards maintaining their health.

Furthermore, dissatisfied clients are inclined to perform an extensive search for health institutions that are capable of providing an affordable and better health care service (Lantis, Green & Joyce, 2002:1). Brassington and Pettitt (2003:96) explain that clients perform an extensive search for information using various information sources. According to Furiji *et al*. (2012:80), Ramsaran-Fowdar (2008:105) and Reimer and Kuehn (2005:786), the information sources used in performing the search for health institutions that offer quality health care services are outlined as follows:

- **Internal sources**: Internal sources are the information and experiences that a client has in its memory about a particular health institution. Mostly, clients that have internal source information are routine purchasers and are loyal to a specified health institution (private or public).

- **Group sources**: In a case where the client is confused, uncertain and inexperienced, information is gathered from their family, friends and colleagues.
- **Marketing sources**: In marketing source, information is gathered by clients through advertisements, health care providers, display and packages.
- **Public sources**: In public sources, clients can gather information from ratings made by independent organisations and individuals or reports given by the media.
- **Experimental sources**: When information obtained from friends and family and other information sources becomes insufficient, clients are coerced to give attention to certain quality signals in the health institution. Clients gather information by assessing the physical environment, equipment, health care provider friendliness and professionalism.

Additionally, Mullins *et al*. (2008:102) propose that the client's search for information will depend on the perceived benefit of the search versus the perceived cost. Mullins *et al*. (2008:102) refer to the perceived benefit as finding the best price, getting quality services and achieving satisfaction with the purchase decision. The time and cost in undertaking the search for information is referred to as the perceived cost.

2.3.2.3 Alternative evaluation

The third stage in the consumer decision-making process is the clients' evaluation of several selected health institutions. At this stage a client accepts, distorts or rejects information given to them by its information sources. Clients also develop an alternative/evaluation criteria based on the type of health care services that they desire to have (Kurtz & Boone, 2010:154). A client evaluates and weighs the attributes and benefits of the health institutions in their evoked set. The alternative/evaluation criteria may be based on the professionalism of the health care provider, price/affordability, quicker response, quality, performance standards, the empathy of nurses and doctors or the appearance/ambiance of the health institution. According to Harris (2003:712), health institutions that desire to retain existing clients and attract new clients should understand the process through which clients evaluate

and choose health institution. In other words, they should prove to clients that all features in their evaluation criteria can be offered to them.

2.3.2.4 Purchase

Purchase is the stage that follows after the evaluation of alternatives. In order to make a purchase, the client evaluates the evoked set of health institutions based on their alternative/evaluation criteria. Thereafter, the health institutions in clients' evoked set are reduced to one (Kurtz & Boone, 2010:156). The client decides whether to go on with the purchase or not. In purchasing the health care services, clients are to decide on when the health care service will be offered, the payment method and the time of payment (Hoffman *et al*., 2005:183). Furthermore, clients with specific health problems are inclined to make decisions on a health institution or physicians that are specialised in treating such ailment (Hibbard, Slovic, & Jewett, 1997:400). This indicates that clients are likely to make purchase decision based on their health needs, price, prestige, service quality, empathy of doctors/nurses and appearance of the health institution.

2.3.2.5 Post-purchase evaluation

The post-purchase evaluation refers to the behaviour demonstrated by clients after the utilisation of health care service regarding a health institution. The post-purchase behaviour (customer satisfaction or cognitive dissonance) that will be exhibited by a client is a result of their level of expectations and the benefits expected from the health care services utilised (Lamb, Hair, McDaniel, Boshoff & Terblanche, 2004:77). Therefore, the post-purchase behaviour is either the clients' satisfaction or the cognitive dissonance experienced from the health care service that has been purchased. According to Brassington and Pettitt (2003:80), the post-purchase evaluation is a new phase in the consumer decision-making process that reveals whether the expectations of the client have been met or not.

The post-purchase behaviour determines whether clients will switch to another health institution or continue to use the selected health care institution (Armstrong & Kotler, 2005:162). In other words, a client that is satisfied with the health care service

might purchase again and recommend the health care service to others. Clients that experience cognitive dissonance might discontinue from using the health care institution and spread the bad service quality by word-of-mouth. Ramsaran-Fowdar (2013:236) affirms that for health institutions to remain competitive and profitable, clients post-purchase behaviour (satisfaction or cognitive dissonance) should be evaluated over time.

2.3.3 Steps in the buying process for services

The steps in the buying process for services are strictly based on the stages that clients will pass through in purchasing services. The buying process for services as presented by Boshoff and Du Plessis (2009:63) in Figure 2.2 is divided into three stages, namely, the pre-purchase, service encounter and the post-purchase stage. According to Boshoff and Du Plessis (2009:62), the pre-purchase stage includes the need recognition stage, information search and evaluation of service providers. The pre-purchase stage in the buying process for services is the stage where clients make a decision to buy and use services. Furthermore, the decision made to purchase services at this stage varies from routine decision-making to an extensive decision-making.

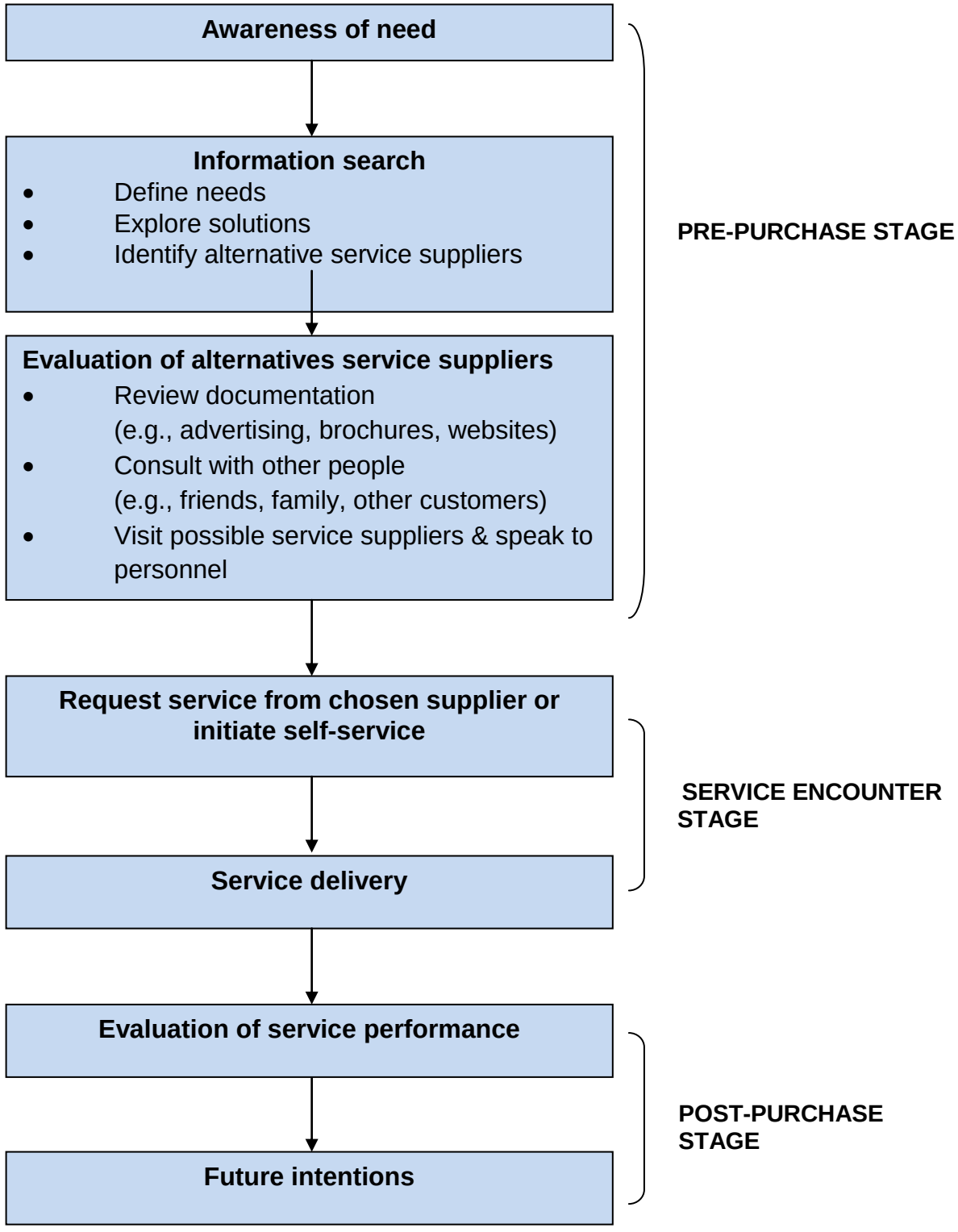
Contrary to the extensive decision-making process, in a routine decision-making, clients do not pass through the entire stages because clients consistently make decision to purchase the services from a particular service provider (Boshoff & Du Plessis, 2009:62). The service encounter stage in Figure 2.2 includes the request of service from the chosen supplier or initiate self-service and the service delivery process. The service encounter stage is the stage in which the service delivery takes place. Clients at this stage encounter or come in contact with other clients, service provider and all other physical evidence presented by the service provider such as the service environment, ambiance, service equipment, communication material, and employees. Clients that seek high contact services especially in health care services may actively be involved in one or more service process (Lovelock & Wright, 2002:75).

The final stage in the buying process for services in Figure 2.2 is the post-purchase stage. The post-purchase stage includes the evaluation of service performance and the future intentions of clients. This final stage allows clients to evaluate the quality of service that has been purchased and the service outcome that shows either their satisfaction or dissatisfaction. The service outcome (customer satisfaction or cognitive dissonance) will determine the future intentions of clients. The future intention of clients might be to remain loyal, continue to patronise the service provider and spread the positive experience by word-of-mouth or quit using the services and spread bad experiences by word-of-mouth (Kasper *et al*., 2006:104).

Figure 2.2 portrays the steps that clients go through in the buying process for services. Figure 2.2 shares the similarity of stages with the above Figure 2.1 of the consumer decision-making process in terms of the awareness of need, information search and evaluation of alternatives. Afterwards the buying process for services progresses into the request for service from chosen supplier stage, service delivery stage, evaluation of alternatives and future intentions. Figure 2.2 will attempt to explain briefly the similarities in stages that it shares with Figure 2.1 and it will provide detailed discussion of the rest of the stages in the buying process for service (service encounter stage and post-purchase stage).

Figure 2.2 illustrates the buying process for services as depicted by Boshoff & Du Plessis (2009:63).

Figure 2.2: The buying process for services



Source: Boshoff & Du Plessis, 2009:63.

The three stages of the buying process for services will be discussed for clarity reasons.

2.3.3.1 Pre-purchase stage

The decision to make use and purchase service occurs at the pre-purchase stage. In order to make the decision to use and purchase service, the client becomes aware of a need, searches for information about where the service can be purchased, weighs the benefits offered by alternative service providers, considers the risks associated with purchasing the service and thereafter makes a decision to purchase the service (Boshoff & Du Plessis, 2009:62). Furthermore, the purchase decision that will be made depends on the needs and expectations of clients. According to Lamb *at al*. (2004:78), the type of purchase decision that clients make is determined by the level of consumer involvement, the amount of time during the purchase process, the cost of the service, the degree of information search and the number of alternatives considered. Therefore, a client can conduct an extensive decision-making process along the pre-purchase stage when the service is expensive, bought for the first time, newly innovated and high in risk while a frequently purchased service with low cost and risk is associated with the routine decision-making (Lamb *at al*., 2004:79). Moreover, the pre-purchase stage consists of the awareness of needs, information search and evaluation of alternative service suppliers.

The pre-purchase stage begins when the client becomes aware of a need or recognises a problem. The awareness of a need may come as a result of the clients' internal stimulus such as hunger and the need to impress people or external stimulus such as an advertisement, word-of-mouth and the development of an innovative service (Armstrong & Kotler, 2005:160). According Boshoff and Du Plessis (2009:63), other reasons that make a client become aware of a need are the availability of new and improved service in the market, a change in the financial circumstances of the client, out-of-stock situations, dissatisfaction and negative experiences related to past service provider.

The search for information is the second stage in the pre-purchase stage that follows after the client becomes aware of a need. The client begins to seek for and gather information in looking for solutions to the unresolved need. The information gathered is used by the client to evaluate the providers of the service (Kasper *et al*., 2006:103). According to Boshoff and Du Plessis (2009:64), the intense search for

information by clients depends on the perceived benefits of the search versus the perceived costs. Furthermore, the perceived benefit includes finding the right price and getting the best service provider that will satisfy their needs. The perceived costs include the amount of time and energy that are used for the information search.

Kotler and Keller (2011:189) argue that clients' search for information can be distinguished into two levels of engagement, namely, heightened attention and active information search. Heightened attention is a milder search carried out by clients as they become more open to information about the services, whilst in the active information search, clients source information through reading materials, friends, online and visits to the service environment. According to McDaniel *et al*. (2006:193), clients can source information internally and externally. Internal information relates to information stored in the clients' memory as a result of their last experience with the service provider, whilst in the external information search, client source for information from the outside environment.

The external information source is further divided into two, namely, non-marketing-controlled and marketing-controlled. The non-marketing-controlled are sources of information that is not associated with the marketers' communication tool but they include personal sources (family, friends and coworkers), personal experiences and public sources (media reports and ratings by independent organisation). The marketing-controlled information source includes advertisement and promotion of the service brand by marketers. Marketing-controlled information sources include mass media advertisement (television, radio, magazine and newspaper), sales promotion (contest, display and premiums), sales people and the internet (McDaniel *et al*., 2006:193). The information gathered is used by the client to reduce the alternative service suppliers to an evoked set. The evoked set is simply the most preferred service suppliers selected or considered by the client (Zeithaml, Bitner & Gremler, 2009:55).

The third stage in the pre-purchase stage of the buying process for service is the evaluation of alternative service suppliers. In evaluating the alternative service suppliers, clients utilise the information gathered from the non-marketing-controlled and marketing-controlled sources to identify the attributes, weigh the perceived

benefits, values and compare the service providers in the evoked set (Hoffman, Bateson, Wood & Kenyon, 2009:90).

2.3.3.2 Service encounter stage

The service encounter stage is the second phase in the buying process for service. This phase of the buying process for service is made up of the request of service from the chosen supplier or initiate self-service and service delivery stage. After the client weighs the cost, benefit, risk and values of all services providers in its evoked set, a preferred one is selected. In other words, in the service encounter stage the client has made a preferred selection of a service provider based on its criteria. As a result of the preferred selection on the service provider, the service is either requested or the client initiates self service (Zeithaml *et al*., 2009:55).

According to Kasper *et al*. (2006:104), the service encounter stage is the consumption stage where the actual service is delivered to the client and the entire service process is evaluated. This stage determines the overall satisfaction level or the cognitive dissonance of clients. During the service encounter stage, the service is purchased, experienced, and evaluated almost simultaneously. This means that clients come in contact with the service personnel (service provider and employees), service environment (interior and exterior of service facility), support service (materials and equipments) and other clients to experience and evaluate the overall service performance (Lovelock & Wright, 2002:90; Zeithaml *et al*., 2009:60). In contrast to the simultaneous purchase and production of service, most clients pay for the services in full or advance and experience the service later. One example is paying for a surgical operation before the actual date of service delivery (Boshoff & Du Plessis, 2009:69). Since services are judged only after the overall service has been experienced, it becomes clearer to the client if the overall service performance exceeds or meets its expectations. In other words, the overall judgment (negative or positive) of the overall service purchased is given by the client (Kasper *et al*., 2006:105). The outcome of service leads to the post-purchase stage where clients are either satisfied with service and continue with the use of the process if it is an on-going service process or discontinue if dissatisfied with the service and cease to use

the service as well as spread negative information about service provider (Kotler & Keller, 2011:194).

2.3.3.3 Post-purchase stage

The post-purchase stage is the final phase in the buying process for services in which the client makes an evaluation of the outcome of service purchased. The post-purchase stage is made up of the evaluation of service performance and the future intentions of clients. The outcome of the overall service results in the clients' satisfaction or cognitive dissonance. In other words, the outcome of service will determine the future intentions of a client (Lovelock & Wright, 2002:90). Furthermore, the client is satisfied if the service performance meets or exceeds its expectations. The satisfied client is likely to rate the service received as high in quality and its future intention is to purchase the service continuously (on-going) and act as a positive referral to other clients that seek a similar service. However, the client experiences cognitive dissonance if the service performance is less than its expectations (Hoffman *et al*., 2009:93). This indicates that clients experience regrets and doubt as a result of the purchase and they tend to qualify the quality of service purchased as being low. Kasper *et al*. (2006:106) suggest that, due to the negative disconfirmation, the client spreads negative information about the service provider, switch service brand, or remain committed or purchase the service again. Furthermore, dissatisfied clients will purchase services again based on three types of commitment, namely:

- **Affective commitment**: The attempt made by the client to continue the use of service as a result of the need to continue relationship with the service provider.
- **Continuance or calculative commitment**: Clients continue the use of service as a result of the high cost associated with switching service brands.
- **Normative commitment**: This is an obligation-based attachment that requires a client to continue receiving the service and continue the relationship with the service provider.

2.4 EVALUATION OF SERVICE QUALITY

Services are deeds, efforts or performances performed by one party to another (Hoffman & Bateson, 2006:5). According to Kotler and Keller (2011:378), a service is an intangible act of performance that is offered by one party to another party and it does not result in the ownership of anything. The production of services provided may or may not be linked to physical goods. Thus, goods are associated with tangibility and can be evaluated before purchase while services are associated with intangibility and can be evaluated after purchase. Therefore, it is important to note that evaluating and making purchase decisions for goods and services differs. In other words, clients find it more difficult to evaluate the nature of service than goods prior to making a purchase decision. This is a result of the intangible nature of services and implies that clients are unable to evaluate (see, hear, smell and touch) the quality of what they intend to purchase. In contrast, clients can evaluate (see, touch, smell and feel) the goods before the purchase (Lovelock & Wright, 2002:84).

Although clients follow similar consumer decision-making process to solve a need, the stages that are followed in purchasing goods and services differ (Zeithaml *et al*., 2009:50). Clients follow a more complex decision-making process in purchasing services than in purchasing goods. Complexity in the process entails that the bundle of characteristics that services has makes it difficult for clients to judge the quality of what is being offered. Characteristics such as, the intangibility, variability, inseparability, perishability make it difficult for clients to evaluate effectively the quality of service prior to purchase (Kotler & Keller, 2011:72). Since services can only be evaluated through the service delivery stage, service providers try to create a situation for quality to be perceived as clients come in contact with their environment. According to Kotler and Keller (2011:71), service providers try to “tangibilise the intangible”. This implies that service providers attempt to demonstrate the quality of their service through physical evidence. The intangible nature of services makes it difficult for services to be seen, tasted, heard, smelt and touched and to reduce this uncertainty. Clients seek evidence of quality through the physical environment and presentation created by the service providers. Specifically, clients seek evidence of quality through the interior and exterior of the service place, employees, equipments, price, symbols and communication materials (Kotler & Keller, 2011:72).

Most often, clients conduct their personal evaluation by getting in contact with the health institution. According to Grönroos (2001:150), the clients make personal assessments of technical and functional quality of health care services. The technical quality is assessed in terms of the physical environment, professionalism, technical precision of diagnosis and treatment by health professionals. The functional quality of health care services is assessed in the manner and process in which the health care service is delivered. An example of functional quality is the relationship between the health care provider and the client (Grönroos, 2001:150). Kotler and Keller (2011:380) stipulate that clients evaluate the technical and functional qualities of the health institutions and its health care services through the following:

- **Health care providers**: Clients search for quality and get satisfied if the empathy, friendliness, care, trust, quick customer service and support of health care providers meet or exceed their expectation.
- **Environment**: Clients search for quality and express a feeling of satisfaction if the interior and exterior of the health institution is carefully planned. In other words, when the health institution is clean, odourless, homely and the ambiance is relaxing.
- **Equipment**: Clients search for quality and express feelings of satisfaction if the health institution has quality and user friendly medical equipment used for diagnosis and treatment.
- **Price**: Clients search for quality and get satisfied if the quality of health care services is affordable.
- **Communication material**: Clients conduct their personal evaluation on communication materials. The client gets satisfied if communication materials convey friendliness and support.

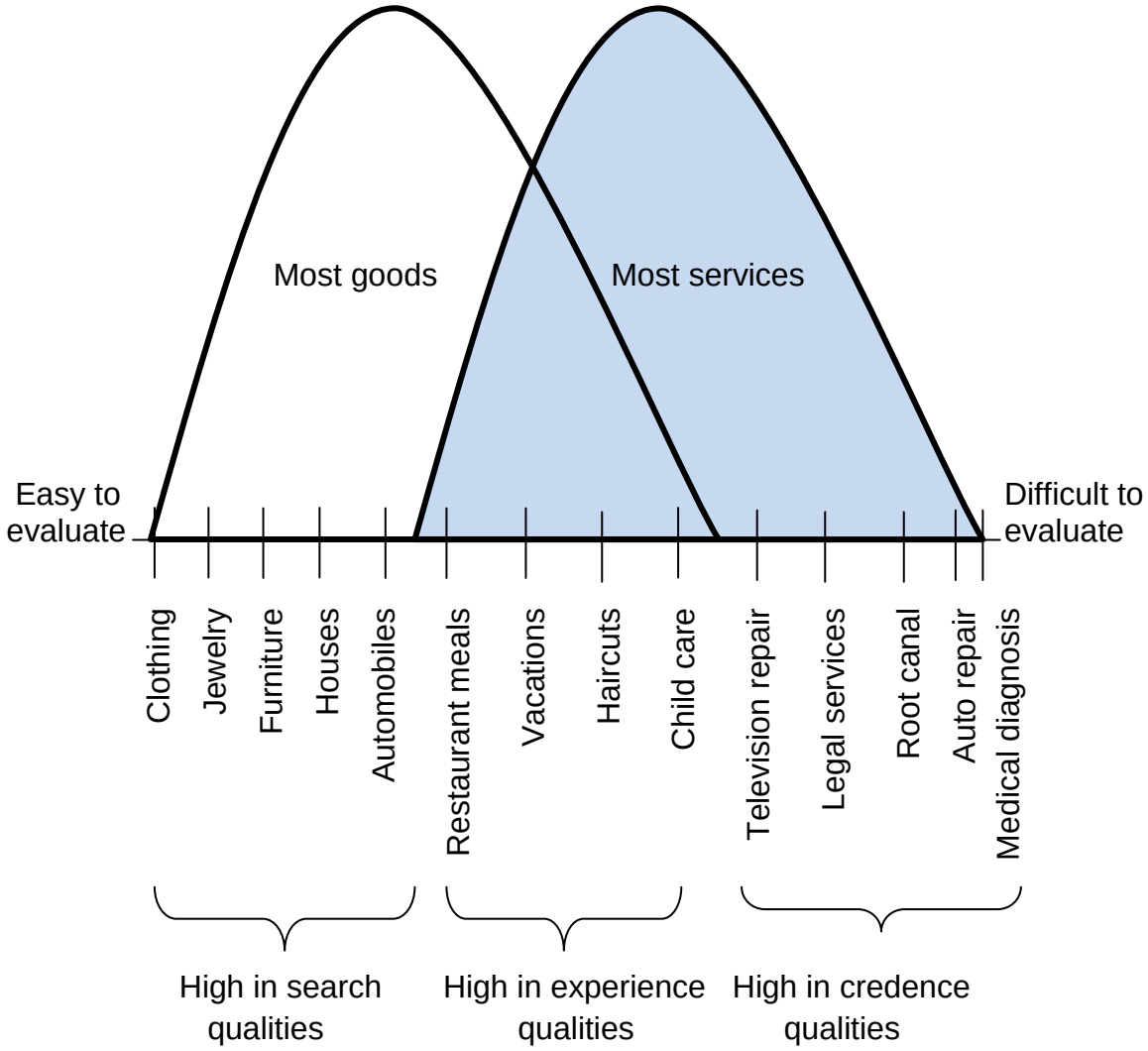
Furthermore, the differences that exist between goods and services as indicated in Figure 2.3 can be divided into three categories of properties of consumer products namely search qualities, experience qualities and credence qualities (Zeithaml *et al*., 2009:50). The continuum of evaluation for different type of products as presented by Zeithaml *et al*. (2009:51) in Figure 2.3 reveals that the search qualities are attributes

that are determined and evaluated by a client before making purchase decision. Search attributes in Figure 2.3 are basically goods such as clothing jewelry, furniture that have colour, prices, styles, fit, feel, hardness and smell and that can be evaluated before making purchase decision.

Lovelock and Wright (2002:84) postulate that the experience attributes in Figure 2.3 relate to the purchase of goods that are backed up with services Experience attributes such as restaurant meals, vacation, haircuts and child care can only be evaluated by clients after purchase. Credence qualities as shown in Figure 2.3 are pure services that clients find difficult to evaluate before and after the purchase decision. Clients find it difficult to evaluate services such as health care services, legal services, banking services, education, auto repair and television repair because of the lack of knowledge and expertise in these fields. Therefore, clients can rarely know if the service offered by the service provider has been poorly or well performed (Bennett, Bove, Dann, Drennan, Frazer, Gabbott, Hill, Lawley, Matear, Perry, Sparks, Summers, Sweeney, Ward & White, 2003:25).

Figure 2.3 illustrates the continuum of evaluation for different types of goods and services.

Figure 2.3: Continuum of evaluation for different types of products



Source: Zeithaml *et al*., 2009:51.

Furthermore, Lovelock and Wright (2002:89) claim that since services are high in experience and credence qualities, clients are exposed to a more perceived risk before making an actual purchase decision. The perceived risk is a significant factor in a client's purchase decision and it refers to any action that a client takes in purchasing services which may produce consequences that have been anticipated but are likely to be unpleasant (Hoffman *et al*., 2009:95). Thus, perceived risks are consequences that clients anticipate prior to purchasing and using services.

The intangible nature of services makes it impossible for clients to be certain about the services they intend to purchase. Therefore, the risk that clients perceive will

determine if the purchase will be made or postponed (Kasper *et al*., 2006:98). Furthermore, the risks perceived by clients differ on the basis of earlier experience (negative or positive) and the type of services that they intend to purchase. According to Kotler and Keller (2011:193) and Hoffman *et al*. (2009:96), the following are the perceived risks that clients face when they make a purchase decision on services:

- **Functional risk**: This is the risk associated with unsatisfactory performance outcomes. Clients debate if the service performance will exceed expectations.
- **Financial risk**: Clients feel that purchasing the service might not be worth the amount paid for it and the consequences might result in monetary loss.
- **Physical risk**: Prior to making a purchase decisions, clients worry that if the service is poorly performed it may pose a threat to their health or well-being.
- **Temporal risk**: Temporal risk is associated with the long time or delay that is experienced by the client before the actual service is performed or purchased.
- **Psychological risk**: Emotional, personal and mental fears associated with the purchase of services.
- **Social risk**: Clients fear that the purchase decision made on the service might create discomfort and humiliation in front of friends, family and colleagues.

Since services are high in credence and experience qualities (difficulty in evaluating it prior to purchase) and the purchase is associated with risk, Boshoff and Du Plessis (2009:69) reveal that clients employ risk-reducing strategies before they make a purchase decision. According to Boshoff and Du Plessis (2009:69), the risk-reducing strategies used by clients are:

- extensive information search from reliable information sources;
- reliance on service provider with good reputation;
- seeking guarantee and warranties from service provider;
- gathering information and advise from knowledgeable service employees;

- visits to service facility;
- performing close evaluation of all physical evidence in the service environment; and
- comparing service offerings with alternative service brands.

2.4.1 Importance of evaluation of service quality and satisfaction

Service quality and client satisfaction are an important discourse and an essential factor that have been explored in health care settings. Improvement in service quality is important to health institutions because it is linked to increased profit margins, repeat purchase behaviour, willingness of clients to pay price premiums, increased positive word-of-mouth and client satisfaction (Bennett *et al*., 2003:77). The importance and awareness of client satisfaction in the health care sector has grown. This growth is evidenced in the numerous researches that have been carried out in the area of medicine and health. Even so, client awareness in satisfaction has increased. In other words, clients have become more demanding in the quality and benefits that they can get from health institutions regarding health care services. This growing demand has increased the intensity of their search for information on quality and cost that meets or exceed their expectations. Currently, clients have more ability to use the information gathered to evaluate quality and a make selection from various health institutions than ever before (Kim, Kim, Park, Kim & Han, 2013:414; Sawyer, Ayers, Abbott, Gyte, Rabe & Duley, 2013:1).

Satisfaction, as a concept in health care settings, has been perceived as complex and often poorly defined. According Weissenstein, Straeter, Villalon, Luchter and Bittmann (2011:1), client satisfaction refers to the discrepancy between the quality of the health care services expected by the client and the perceived quality of health care services. Clients become satisfied when the services perceived performance meets or surpasses their expectations. In other words, client satisfaction is an approval or contentment based on the encounter and experiences of the quality in health care services purchased (Armstrong & Kotler, 2005:162; Bitner & Hubbert, 1994:77).

The satisfaction of clients is paramount because the objective of health institutions is to retain existing and gain new clients. Therefore, to remain profitable and successful it is necessary that health institutions use the satisfaction level of clients as an important indicator in measuring their performance quality. Otherwise, clients that are unhappy with the health care service purchased might discontinue from using health care service and spread negative experience by word-of-mouth. This situation might result in the health institution losing existing and prospective customers. Therefore, Bennett *et al*. (2003:77), Damouni (2012:1), Dovalienė, Gadeikienė and Piligrimienė (2007:59-67) and Mullins *et al*. (2008:106) insist that measuring the satisfaction level of clients regularly can give the health institution the following benefits:

- competitive advantage over other health institutions;
- increase positive word-of-mouth advertisement;
- attract new clients;
- lower the cost of attracting new clients;
- encourage repeat purchase;
- leads to clients' loyalty; and
- leads to the rentention of existing client.

Furthermore, clients' satisfaction with the quality of health care services purchased is likely to create a better or worst health outcome. The research findings by Waldenstrom, Hildingsson, Rubertsson and Radestad (2004:17) reveal that mothers that are not satisfied with the health care services purchased during child birth might increase the rate of abortion in the future and increase the need to perform a caesarean operation. Mothers are also likely to have negative attitudes towards the new-born child. Kim *et al*. (2013:414), Ilioudi, Lazakidou and Tsironi (2013:71-73) and Mashego and Peltzer (2005:20) suggest that client satisfaction can help the health institution to achieve the following:

- improved employee morale and improved implementation of health care programmes that leads to improved client well-being and needs;

- minimised risk and reduced factors that influence client's satisfaction. An example of factors that influence client satisfaction are client lengthy waiting time and cost;
- strengthened management structure and development of innovations; and
- improved quality of health care service delivery. The health care providers will focus more on clients than on the process, get clients informed and allow room for decision-making, show empathy, care and professionalism.

2.5 CONSUMER INVOLVEMENT

The amount of time and energy that a client invest in searching for information and evaluating alternatives in the decision-making process of consumer behaviour is referred to as a consumer involvement. In other words, a client that seeks a surgical operation that is relevant to its well-being will take much time and effort to search for information on health care providers and perform critical evaluations of all service providers in general and in its evoked set (Lamb *et al*., 2009:67). According to Lamb *et al*. (2009:67), consumer involvement is the most significant determinant in classifying the purchase decision made by clients. This indicates that clients are highly involved in making an extensive purchase decision on costly, risky and infrequently bought service. Clients take a longer time to perform high internal and external information search in order to make the right purchase.

Furthermore, the degree of personal relevance that a client attaches to the purchase of a service is called consumer involvement. The degree of personal relevance determines the degree of search and evaluation and the length of time that the client takes in the consumer decision process (Hoffman *et al*., 2005:186). Furthermore, Hoffman *et al*. (2005:186) state that consumer involvement has evolved from the degree of relevance that a client attaches to a service to the level of interest that a client has on a service. In other words, whilst health care and education are relevant to clients, it is possible that some clients will be more involved and interested in making purchase decision on the need for wellness than in the pursuit of an additional educational degree.

Furthermore, as a result of the degree to which a client needs and finds a service interesting, Hoffman *et al*. (2005:186) stipulate that there are two forms of consumer involvement, namely, enduring involvement and situational involvement. The degree of interest that a client feels about a service on an on-going basis is an enduring involvement while situational involvement is the degree of interest that relates to a specific occasion or situation (purchasing certain service to boost ego, to impress an important person or purchasing because the situation warrants it). Additionally, consumer involvement is the degree to which a client feels attached to a product or a product category. A health care provider is likely to feel strongly attached to the purchase of medical equipment and less attached to the purchase of musical equipment (Blythe, 2006:122). Thus, it can be argued that the degree of importance, degree of interest of a service to a client and the length of time and energy that a client takes in searching and evaluating services brands in the decision process is referred to as consumer involvement.

The level of consumer involvement is different for all purchase decisions made by clients. Consumer involvement has three types of levels that are significantly related to how clients make purchase decisions. The three levels of the consumer involvement are high involvement, medium involvement and low involvement (Blythe, 2006:123).

High involvement is associated with an extensive decision-making or a complex buying behaviour (Lamb *et al*., 2009:67). According to Blythe (2006:123), high involvement clients are hard to persuade through several communication tools. Since the services to be purchased is expensive, high in risk and unfamiliar, clients try to get the purchase right, to have an in-depth knowledge of the service to be purchased through an extensive information search and they are likely to ignore other information that is not similar to their purchase (Blythe, 2006:123).

The **medium involvement** is related to a limited decision-making where the amount of time and effort that clients take in purchasing is neither too low nor high. The moderate time and effort expended in this type of purchase decision is a result of the clients' past experience and use of the service. Specifically, as result of switching brand the client becomes moderately involved in the buying process for service

(McDaniel *et al*., 2006:199). The client is familiar with the nature of service offered due to past information gathered but unfamiliar with the quality of services of each alternative service provider. Due to the unfamiliarity, the client moderately goes through the buying process again. Therefore, to purchase the service of an alternative service brand, clients engage in a medium involvement. This indicates that clients perform a moderate search for information, consider a few alternatives and spend a moderate time in making purchase decisions (McDaniel *et al*., 2006:199).

In **low involvement**, clients purchase services frequently from the same service provider with less time and energy. The time and effort that the client takes to make a purchase decision is short as services have been purchased before (Boshoff & Plessis, 2009:60). In other words, low involvement is associated with the routine decision-making process where clients require short time to make a decision of frequently purchased low cost services from the same service provider (Lamb *et al*., 2009:67).

2.5.1 Determinants of consumer involvement

The previous discussion of consumer involvement implies that clients pass through the buying process for service and make purchase decisions depending on their level of involvement with the services that they seek to purchase (Mullins *et al*., 2008:107). According to Lamb *et al*. (2009:68), the level of consumer involvement is determined by several factors which influence the clients' level of involvement. The differences in the level of clients' consumer involvement is dependent on five factors, namely, previous experience, interest, perceived risk of negative consequences, situation and social visibility (McDaniel *et al*., 2006:200). According to Lamb *et al*. (2009:68) and McDaniel *et al*. (2006:200), the factors that determine the level of consumer involvement are:

The **previous experience** of the services purchased by a client is likely to influence the level of consumer involvement. This indicates that, when a client purchases a service repeatedly, the nature of the service and service provider become familiar and known to the client. Due to previous experience and familiarity of service

offering, service providers, risk and benefit, a client that seeks the services of a dentist will spend less time and effort in searching for and evaluating service providers or the client may ignore the pre-purchase stage and move straight to the service encounter stage (Juliusson *et al*., 2005:562).

The service that a client is **interested** in significantly influences its level of involvement. There are so many areas of services that clients find interest in such variety as entertainment, health care, education, legal and banking services. The areas of interest differ from one client to another. This indicates that most clients will find attending a jazz concert interesting and a public lecture on health less interesting and, in reverse, clients whose interest is in health education will find a health lecture interesting and a jazz concert uninteresting. Therefore, a client whose interest of need is related to education would take longer time to evaluate and search for educational institution that is right for its needs. Therefore, a service that a client finds interesting is related to high involvement and low interest is associated with low involvement (Hoffman *et al*., 2005:186).

The **perceived risk of negative consequence** has a direct influence on the level of consumer involvement. In purchasing services, clients are exposed to certain risks such as financial, social, psychological, functional and temporal risk. The high risk perceived by a client is associated with a high consumer involvement purchase. In other words, a client that perceives a high functional risk (unsatisfactory performance outcome) associated with the purchase of a service is likely to engage for a long time and high cost in searching for and evaluating many service providers. Therefore, a high consumer involvement is related to a high perceived risk of negative consequence (Lovelock & Wright, 2002:89).

The **situation** that a client finds itself in, determines the level of consumer involvement. A client's situation can change from a low level involvement to a high level involvement. This indicates that, if a service provider that frequently provides service for a client suddenly goes out of business or fails to continually satisfy its client, it is likely that the client will purchase the service from alternative service providers. Due to switching service provider, the client engages in a high or moderate consumer involvement. This situation of dissatisfaction or closure of the

service provider propels the client to make a high or moderate search for alternative service providers and thus the client spends long or moderate time and cost in evaluating other alternative service providers (Lamb *et al*., 2009:68).

Social visibility also influences the level of consumer involvement which increases as the social visibility of a service increases. Social visibility means that the services to be purchased carry a high social risk. These services are often on social display and when bought can boost the ego or personality of a client. However, the purchase of health care service from a renowned and costly private health institution with social visibility carries a social risk. Social risk, in this type of purchase, implies that clients would want to purchase health care service from the private health institution to impress family, friends and colleagues. In other words, a high social visibility service that carries a social risk creates an impression and statement about a client (McDaniel *et al*., 2006:200).

2.6 DECISION-MAKING IN THE HEALTH SECTOR INSTITUTIONS

In health care settings, there has been growing interest in clients' involvement in making clinical decisions on their health and treatment. Clients' involvement in the decision-making process entails making choices in satisfying their need for wellness as a result, the client passes through the buying process for services. A client recognises a need for wellness, searches for information on wellness programmes and the health care institution to utilise, evaluates selected health institutions, purchases health care services and evaluates the health care services (Murray, Pollack, White & Lo, 2007:1). In other words, clients that seek to get their need for wellness satisfied for the first time pass through the pre-purchase stage, service encounter stage and the post-purchase stage.

Since health care services are high in credence qualities and involve tangible actions, clients are uncertain about the quality of the health care services to be purchased. In other words, credence properties do not allow clients to know exactly what he/she is purchasing or has consumed even after consumption. Tangibles are easy to decide on as they are visible, can be touched and smelt before a decision is made by a consumer. Further, tangible actions indicate that health care providers

offer health care services purchased on clients' body and the overall quality of the services can only be evaluated after purchase. This implies that clients are likely to evaluate the quality of services purchased by what they saw and by the way they were treated and handled by health care providers (Bennett *et al*., 2003:10). Moreover, a client may be able to evaluate the quality of services in terms of the physical evidence in the service environment prior to purchase but may experience difficulties in evaluating the success or quality of a surgical operation delivered unless the client is knowledgeable in the area of medicine (Bennett *et al*., 2003:9).

Furthermore, there exists some characteristics of services that make it impossible for a client to be certain about the quality of health care services prior to purchase. These characteristics are intangibility, inseparability, heterogeneity and perishability (Bennett *et al*., 2003:31). According to Bennett *et al*. (2003:31), the following are characteristics of such health care services:

The nature of the **intangibility** of services is such that clients cannot see, touch, taste and hear the health care service before purchase. Due to the intangibility of health care services, clients search for quality of services from the physical evidence in the service environment. In order for clients to reduce the uncertainty associated with the purchase of health care service, they search for quality signals from the interior and exterior of the building, equipments, the presence of smell, dirt, noise in the health institution, friendliness, support and empathy of health care provider and their employees (Kotler & Keller, 2011:380).

Unlike physical goods that have a separate process of production, distribution and consumption, the process of production and consumption of services is **inseparable** and occurs simultaneously. In other words, it is often difficult to separate the service from the service provider. A surgeon cannot perform a surgical operation without the presence of the patient (client). Therefore, the health care provider plays a significant role in interacting with and affecting the clients' satisfaction and perception of quality in the health care service delivered (Hoffman *et al*., 2009:31).

Heterogeneity in services implies that the services provided by service providers in a similar service sector differ. In other words, variability exists in the quality of

services provided by similar health care providers, where and when the service was provided. In health care settings, a health care provider in a public health institution may not be able to show empathy and give the same support and care like a health care provider in a private health institution (Hoffman *et al*., 2009:38).

Perishability in services means that services cannot be stored or returned after purchase. This implies that services produced by a service provider can be delivered on a set time and cannot be kept for consumption at a later time. A patient that missed an operation date cannot rewind the time to get or rebook the same time operation date from the surgeon in the same manner and time (Kotler & Keller, 2011:383).

Therefore, the characteristics that make the quality of services uncertain make clients highly involved in the buying process for services. Clients identify what they want by relying heavily on word-of-mouth and they get involved in an extensive decision-making process. Clients spend a long time in the decision-making process and high cost on internal and external information search and evaluation of a number of health institutions (Kotler & Keller, 2011:379). In order to get their first purchase right, clients weigh the perceived benefit, cost and perceived risks of the health institutions in their evoked set and, afterwards, make a selection (Bennett *et al*., 2003:32). During the service encounter stage, clients come in contact with the health institution. According to Reiling, Hughes and Murphy (2008:168-180), clients seek the following:

- **Timeliness**: The promptness with which health care providers attend to their needs. Clients want to spend a shorter waiting time.
- **Patient centeredness**: The ability of health institution to provide sufficient space (single room beds) for clients' privacy and comfort for family during visit.
- **Safety**: Preventing adverse events such as the spread of disease and complications, avoiding injuries of health care provider and client during treatment, ensuring that the room is clean, odourless and pleasant.

- **Professionalism**: Providing clients with the accurate diagnosis and treatment with the use of up-to-date equipment. Clients desire health care providers that are friendly, caring, supportive, empathetic, communicate effectively and respect their confidentiality.
- **Decision-making**: Clients want access to health care information and high participation in decision-making related to their health and treatment options.

Furthermore, numerous health institutions are recognising the importance of the consumer decision-making process (Broadstock & Michie, 2000:191). The consumer decision-making process in the health care sector is being regarded as legal and ethical. In other words, it gives clients the opportunity to choose from health institutions that offer quality health care services on treatment and wellness. It also allows clients to make decisions about health related treatment. Since the consumer (client) decision-making process in the health care sector is regarded as ethical and legal, clients are given the freedom, by health care providers (purchase act stage), to provide consent in the application of treatment after all information relating to treatment has been given to them (Broadstock & Michie, 2000:191). This type of decision made by clients is referred to as informed decision-making. Clients are clearly informed about the nature and condition of diseases that are addressed, the nature of health care service that is provided, the risk, benefits and complications of the treatment. Afterwards, clients make clinical decisions that are based on their individual preferences and values or postpone decisions to a later time (Briss, Rimer, Reilley, Coates, Lee, Mullen, Corso, Hutchinson, Hiatt, Kerner, George, White, Gandhi, Saraiya, Breslow, Isham, Teutsch, Hinman & Lawrence, 2004:67).

However, Deshpande, Menon, Perri and Zinkhan (2004:501) argue that the majority of clients allow the health care providers to make clinical decisions on their behalf due to the level of professionalism shown in their field. In some cases, it is difficult for clients to make decisions for themselves. The clients' inability to make clinical decisions might be the result of their lack of knowledge in medicine, the level of uncertainty about the diseases or the current state of their health condition (unconsciousness). In such cases, the health care providers are given the role of active decision-makers that determine the outcome of the clients' health (Thompson,

Cullum, McCaughan, Sheldon & Raynor, 2004:68). Thompson *et al*. (2004:68) reveal that this type of decision-making is referred to as an evidenced-based decision-making. The evidenced-based decision-making actively use combined information and knowledge from the providers' years of professionalism and the patients' preference to make clinical decisions. Thus, the evidenced-based decision reduces the clients' level of clinical uncertainty and ensures that a particular course of action taken by health care providers is likely to lead to the desired outcome of client wellness. Due to the credence properties of health services and the level of expertise among consumers, health care providers' decision should be respected by the consumers of health services.

Furthermore, Elwyn, Frosch, Thomson, Joseph-Williams, Lloyd, Kinnersley, Cording, Tomson, Dodd, Rollnick, Edwards and Barry (2012:1361) assert that clinical decision in the area of treatment and wellness should rest on the client and the health care providers. This type of decision-making is referred to as shared decision-making because it involves both the client and the health care providers. According to Alrashdi and Al Qasmi (2012:396), this type of shared approach to decision-making is informative and gives clients the opportunity to negotiate and exchange personal information with health care providers. Health care providers support and help clients to make decisions on a particular course of action regarding their health. The health care providers ensure that the health care services provided respond to what matters to the client (Briss *et al*., 2004:67).

The consumer decision-making process is very important in the health care settings. Clients are expected to make decisions on health care services, health institutions and treatments. The clinical decisions that clients make about the use of health care services is complex. Clients often gather information to gain more knowledge of and insight into wellness programme and diseases before the purchase of health care services but the information gathered is characterised by terms and concepts that cannot be comprehended (Shaller, 2005:18). According to Arnold (2007:3), this complexity in decisions made about health care services puts up a barrier for clients. Therefore, clients are unable to make better decisions regarding health institutions, on wellness programmes to solve their need. Insufficient information on cost and quality regarding health institutions becomes difficult. Clients are also uncertain

about the nature of diseases, the equipment in health institutions, the quality of health care services and treatment that can be offered.

Furthermore, the decisions made by clients, regarding health care services, are often based on the cause, the intensity of the sickness and the importance a client's need to look after its health (Askham, Coulter & Parsons, 2008:1). The purchase decisions that clients make on health care services and health institutions can create a better or worse health outcomes. In other words, a client can select a health institution that has specialised health care providers that offer cure for the disease or inexperienced health care providers that can worsen a client's health situation. Therefore, good sources and understanding of information gathered as well as the right decision made regarding health institutions will improve the well-being of a client. Due to better health outcome, clients will demand high-quality health care services from health institutions (Arnold, 2007:1).

Additionally, the decisions made regarding the utilisation of health institutions is also based on the characteristics of a client. These characteristics are the cultural, personal, social and psychological attributes that concern the client. Client socio-economic characteristics such as ethnicity, gender, age and income can influence a client's purchase of health care services from a private health institution (Arnold, 2007:3). A clients' lifestyle, taste, values, preferences and expectations can also determine the purchase decision about health care services from a private health institution. In other words, the clients in the upper class can make a decision to utilise health care services from a private health institution or travel abroad to seek health care services in contrast to clients in lower class (Armstrong & Kotler, 2005:148).

The consumer decision-making process in this study depicts how clients recognise their need for wellness, their search for information on the health institution to use, evaluation of various health institutions, purchase decision, purchase act, post-purchase evaluation and future intentions on the private health institution which they select. The consumer (client) decision-making process has given clients the ability to stay informed and make favourable choices on the basis of the quality of health care provided by the private health institutions. In other words, clients conduct an in-depth

search of information regarding the private health institution and make choices on the private health institution that provides quality health care service that is appropriate to their need (Hibbard *et al*., 1997:395). Hibbard *et al*. (1997:395) assert that the consumer decision-making process provide strategies that create a reformation in the health care sector. According to Hibbard *et al*. (1997:395), the reformation in the health care sector is expected to result in the following improvements:

- create a healthy competition between health institutions;
- propel health institutions to improve their service delivery;
- expand clients' knowledge of the concepts of quality in health care service;
- change clients' expectations of health care service; and
- influence clients' decisions regarding health institutions.

2.7 BENEFITS OF THE CONSUMER DECISION-MAKING PROCESS

Clients are the reason why every business is developed and they are significant for the sustainability of the business. In other words, health institutions that wish to sustain their businesses and avoid liquidation need to understand the consumer decision-making process to retain existing clients and attract new clients (Blythe, 2006:103). Therefore, to remain successful and profitable there is a need for marketers or health institutions to understand the process clients go through to make choices and the factors that influence the decision-making process of clients regarding the utilisation of health care services and health institution (Armstrong & Kotler, 2005:162).

Furthermore, Kotler and Keller (2011:188) refer to health institutions that understand the consumer decision-making process as 'smart'. Health care providers that are smart study the clients' experiences in learning, choosing, using and disposing a product. Zeithaml *et al*. (2009:50) postulate that the aim of every service provider is to ensure the economic survival of their business. In surviving, health institutions have to understand the differences that exist between the consumer decision-making process for goods and services so that they can develop offerings that will satisfy

consumer needs and expectations. A critical understanding of the consumer decision-making process and buying process for service is beneficial to the health care providers, as it allows them to craft effective service marketing that is focused on the clients. In order to craft an effective marketing that is focused on clients and design services that meet or exceed clients' expectations, service providers need to know what the clients want and understand the nature of their actual experiences at the service encounter stage (Lovelock & Wright, 2002:91). The benefit of this knowledge of the clients' want and understanding of the service process will assist health care providers to detect and highlight problems, craft strategies to solve them, create supporting services and identify opportunities, especially, in the service delivery process (Lovelock & Wright, 2002:91). According to Kotler and Keller (2011:190), the benefit of understanding the consumer decision-making process is as follows:

- **Identify competitors**: The consumers' decision-making process will help health institutions to identify the characteristics that guide the client decision-making in order to understand and identify the different competitive forces through the clients' evoked set. The evoked set is the number of alternatives that is considered by the client during the evaluation of alternative stage in the consumer decision-making process.
- **Craft effective marketing strategy**: Identifying competitors and understanding their weakness and strength will help health institutions to craft effective market strategy that will get its brand into the prospects' awareness, considerations and choice sets.
- **Competitive appeals**: Identifying competitors through the clients' evoked set will help health institutions to plan appropriate competitive appeal. In order to plan an appropriate market appeal, marketers must identify the information sources of clients and evaluate their relative importance. Questions on how clients heard about the health institution and service, sources of information and importance of the sources of information will help the health institution to communicate effectively through advertisement to clients.

- **Better quality of service**: Health institutions that have researched the consumer decision-making process and the factors that influence it will endeavour to offer better quality of health care service to its clients. In order to stay competitive, successful in retaining existing clients and gaining new ones health institutions will strive to offer better quality of service.
- **Boost sales**: Understanding the consumer decision-making process and factors that influences it can boost the sales of health institutions by launching attractive advertisements that trigger the clients' need even if they do not perceive a need. Advertisements of the health care service are important and beneficial as they can propel clients to purchase.

Furthermore, clients that are satisfied with the health care service can spread positive word-of-mouth, thus increasing sales and the clientele base of the health institution (Armstrong & Kotler, 2005:163).

2.8 CHALLENGES OF THE CONSUMER DECISION-MAKING PROCESS

Cognitive dissonance often comes after the purchase of health care services. According to Kurtz and Boone (2010:156), cognitive dissonance is an anxiety felt by a client over the health care services utilised. Furthermore, the anxiety felt by clients is a result of inconsistency among beliefs, attitudes, emotional reactions and knowledge that occur after the purchase of health care services. Gilbert (2003:60) defines cognitive dissonance as a feeling of remorse that a client expresses over the purchase of health care services. The client doubts whether the right decision has been made regarding the health institution utilised. According to McDaniel *et al*. (2006:197), an inner tension experienced by a client after the recognition of an imbalance between behaviour, values and opinions is cognitive dissonance.

The post-purchase outcome on purchase decision made by consumers on a selected service may either bring satisfaction or cognitive dissonance. Clients evaluate the service quality by assesing if the service provided meets or exceeds their expectations. Clients become satisfied when a high quality of service is purchased or when the service provided meets or exceeds their expectation

(Lovelock & Wright, 2002:90). A satisfied client expresses happiness over the purchase of a service. The satisfaction derived from purchases can make the client repeat the purchase and to recommend the service purchased to others. However, a client that is not satisfied expresses doubt, disapproval or unhappiness over the service purchased. The state of unhappiness over the service purchased can result in the consumers' disposal of the service (Kotler & Keller, 2011:194).

According to Kasper *et al*. (2006:105), the dissatisfaction, doubt, disapproval of and unhappiness over the overall service purchased is cognitive dissonance. Kasper *et al*. (2006:105), refer to the cognitive dissonance as a negative disconfirmation that arises when expectations do not exceed actual experience. Due to the doubt, discomfort, dissatisfaction experienced by the client regarding the health care services purchased, Kotler and Keller (2011:194) suggests that clients can do the following:

- stop using the health care services if it is an on-going service;
- spread bad word-of-mouth;
- complain about the health care services; and
- seek assurance from health care providers, friends and family (positive reinforcement).

Cognitive dissonance in the consumer decision-making process poses a challenge to the service provider and the clients. In other words, the challenge faced by the service provider is that they can no longer retain existing clients and attract new ones. When an overall poor service is provided, it results in the client switching service providers. Poor services may consist of mistakes during the service process, wrong billing or service failure that causes a threat to clients. Poor service may also be caused by a service employee who may have been uncaring, impolite and lacking in knowledge (Kasper *et al*., 2006:107). Thus, when clients no longer patronise a health institution the likelihood of the health care provider running out of business is high. The challenge experienced by clients, because of cognitive dissonance, results in monetary cost (feelings that the services provided was not worth the amount paid), social cost (embarrassed in front of family and co-workers) psychological cost or

emotional trauma (aggressiveness, frustration, anger and anxiety). Due to cognitive dissonance, clients complain, suffer in silence or switch service brands (Kasper *et al*., 2006:107).

Furthermore, when a client experiences cognitive dissonance as a result of the purchase of health care services they become alert to information that supports their decision. According to Lamb *et al*. (2004:78), clients rely on word-of-mouth to reduce cognitive dissonance. Moreover, clients may consciously or unconsciously seek positive information that supports the health care services they purchased or justify their reasons for the decision they made on purchase and avoid information about other health institutions that they did not chosen. Since services cannot be returned, it is likely that clients will switch to an alternative service provider (McDaniel *et al*., 2006:197). According to Boshoff and Du Plessis (2009:72) and Kurtz and Boone (2010:156), the challenge of cognitive dissonance experienced by a client is likely to increase when:

- an alternative health institution that should have been chosen offers more benefit and better quality of health care services;
- increased cost in the health care services purchased;
- irrevocability of the decision. Since services cannot be returned, there is a likelihood that the client might have high anxiety surrounding the purchase; and
- the importance of the decision to the client and the difficulty of choosing between alternative health institutions.

2.8.1 Strategies to cognitive dissonance

Understanding the consumer decision-making process and the challenges that the process poses to clients is important for health institutions in reducing cognitive dissonance and to retain existing and attract prospective clients. According to Lovelock and Wright (1999:76), in reducing cognitive dissonance, service providers have to create effective ways to address the expectations of clients and enhance the perception of service satisfaction. Bose and Sarker (2012:192) assert that reducing

cognitive dissonance can help health institutions create a positive brand image. In order to reduce cognitive dissonance Bose and Sarker (2012:219) and McDaniel *et al*. (2006:197), state that health institutions should employ the following strategies:

- carry out an extensive research into the causes of the dissonance and reduce it;
- provide clients with sufficient information that supports the health care services provided;
- devise health care programmes that are targeted to meet the needs of clients;
- focus on clients, and benefits that can be offered than in the process of treatment;
- provide a platform that encourages clients' complaints or feedback;
- attend quickly to complaints and resolve them accordingly;
- provide extra customer service during and after purchase;
- send post-purchase thank you cards, congratulatory message that the right purchase decision has been made and letter or instruction booklets;
- offer a guarantee; and
- employ communication tools that display the superiority of the service brand.

2.9 SUMMARY

The consumer decision-making process has become an important and prominent research topic for all sectors in the economy, in recent years. The consumer decision-making process model for goods and services has provided marketers with the ability to understand the different stages that clients go through to solve their problems. These stages that involve how clients recognise a need, gather information, evaluate alternatives and services, purchase, consume. The post-purchase actions that follow have given marketers the opportunity to come up with effective marketing strategies on how to retain and attract clients.

This chapter highlighted consumer involvement and the type of purchase decisions that is utilised by clients depending on the buying situation (purchasing new and

frequent goods and services). In other words, the purchase decision made by the client depends on the buying situation and is determined by the degree of search, evaluation and length of time it takes the client in the consumer decision-making process and services process.

Furthermore, customer satisfaction and cognitive dissonance comprises the post-purchase behaviour that is demonstrated by a client after the purchase of goods and services. The post-purchase behaviour (customer satisfaction or cognitive dissonance) demonstrated by a client provides an important lesson for health institutions to learn how to improve the quality of services and to craft effective marketing strategies in retaining and attracting clients.

The subsequent chapter will provide a discussion of the health care sector in general and in Nigeria in particular. This chapter will highlight the levels or the structure of the Nigerian health care system and the roles that are played by the government, health organisational agencies and the private health institutions. The challenges in the private and public health sectors and strategies will also be discussed in the following chapter.

CHAPTER THREE
HEALTH CARE SECTOR IN NIGERIA

3.1 INTRODUCTION

The health care sector forms a significant part of a country's economy and it is responsible for providing health care services for the well-being of all citizens. The prosperity and development of the economy of a country depends on how well the health care sector meets the health needs of its workforce. This indicates that the quality of health care services accessed by the work force of a country will promote their well-being and impact on their ability to reach their full potential and positively affect their productivity. Thus, numerous countries strive hard to make health care services accessible and affordable to all its citizens (Obansa & Orimisan, 2013:221).

The health care sector is made up of various bodies, people and actions whose intention is to influence the determinants of health by coming up with innovative programmes that are meant to improve health care services. These actions are for the promotion, restoration and maintenance of health care services in a country (WHO, 2007:2). Furthermore, the health care sector goes beyond the facilities of the health institutions to encompassing all the actions that involve health care delivery. These actions relate to the provision of health care to homes, public and private health institutions, other specialised health care providers, behaviour change programmes, health insurance companies, occupational health and safety regulatory bodies as well as the ministry of health (WHO, 2007:2).

Furthermore, the actions of the health care sector are guided by health policies and regulations which are different across countries. These policies and regulations are influenced by the political, social and economic conditions of a country (Dean & Fenton, 2010:1). These health policies and plans are formulated to ensure their effectiveness in the health care sector as well as to meet the health needs and goals of the entire population of a country. An additional fact to consider is that the health care sector is determined by how far the citizens of the country can access and afford health care services. This indicates that, the health care sector of a country will be effective if the health goals and health needs of its citizens are met (WHO,

2007:7). According to Agency for Healthcare Research and Quality (AHRQ) (2013:1), access to health care services in the health care sector ensures that all citizens of a country have access to quality health care services to achieve their need for wellness. In order to have access to health care services clients are required to gain entrance into the health care sector through sources of information on where health care services can be provided and find the health institutions that can meet their need for wellness. Furthermore, AHRQ (2013:1) states that the access to health care services can be measured by the availability of clients' resources such as, personal finance or health insurance coverage, clients' assessment of the ease with which they gained access to health care services and the outcome of the health care services they purchased.

This chapter deals with the general overview of the Nigerian health care sector. It provides literature on the structure of the Nigerian health care sector. The role played by the government, private health institutions and other health regulatory bodies will be highlighted and discussed in this chapter. The challenges of and strategies for an effective health care sector will also be discussed.

3.2 OVERVIEW OF THE HEALTH CARE SECTOR IN NIGERIA

The Central Intelligence Agency (2013:1) reports that Nigeria is located in the West of Africa and is the third largest economy in Africa. This developing country is regarded as a middle income and mixed economy and is the most densely populated country in Africa with more than 250 diverse ethnic groups and a population of 174.5 million in 2013 and an annual population growth rate of 2.54%. Furthermore, Nigeria is governed by three tiers of government (federal, state and local government). Nigeria is made up of 36 states and a federal capital territory (FCT) that is grouped into six geopolitical zones (North-Central, North-East, North-West, South-East, South-South, and South-West) with 774 constitutionally recognised local governments across the 36 states (National Population Commission NPC Nigeria and ICF Macro, 2009:1).

The Nigerian economy comprises numerous sectors. Amongst these is the health care sector. In the health care sector, provisions of health care services are made

available to the citizens by the three tiers of government (federal, state and local government). The private health institutions and other private health care providers also play a significant role in delivering health care services to Nigerian citizens (Awoyemi, Obayelu & Opaluwa, 2011:2; Oyebanji, 2013). In addition, the federal government's role in the provision of health care services is limited to the affairs of the university teaching hospitals and federal medical centers. Whilst the state government takes responsibility of the general state hospitals and comprehensive health centers at state level, the local governments focus on providing primary health care services through the primary health centers and clinics at local levels as well as dispensaries (Olakunde, 2012:5).

Irrespective of the role played by the Nigerian federal government in making health care services accessible, WHO (2000:154) reveals that the Nigerian health care sector is in a pitiful state and ranked its overall health system performance as 187th position out of 191 member countries that were accessed. SHOPS Project (2012:1) reveals that many Nigerians still have poor health as compared to other countries with similar per capita income. Poor health is attributed to the lack of knowledge about the use and importance health care services, inaccessibility of health care services, poverty and inability to pay costly and quality health care services and the health beliefs that hinder the use of health care services (Emmanuel, Gladys & Cosmas, 2013:2).

Despite the effort made by the government, through the Millennium Development Goals (MDGs), in reducing the maternal mortality ratio by three quarters between 1990-2015, WHO (2012:22) reports that Nigeria accounts for one third of global maternal deaths and contributes 14% of the maternal mortality rate of the world's population whilst India accounts for 19% (56,000) of one third of global maternal death. WHO (2013:24) further postulates that the maternal mortality ratio is 630 maternal deaths per 100,000 live births. This indicates that, the number of maternal deaths amounts to forty thousand per 100,000 live births, whilst the maternal mortality ratio per 100, 000 live births for Sweden is 4, Burundi is 800, South Africa is 300 and 1100 for Chad (highest in Africa region). Furthermore, NPC and ICF Macro (2009:xxvii) state that despite the role that the government plays in the provision of quality and affordable health care services and in reducing two-third of mortality rate

of infant under five years of age, most children do not live to see their fifth birthdays. According to UNICEF (2013:2), 70% of one out of five children in countries such as, Nigeria, India, Afghanistan, Ethiopia, South Africa and Chad are not protected from diseases that can be prevented by vaccines.

The Nigerian health care sector has had several pitfalls which are compounded by many problems (Osain, 2011:470). Despite the strategic position that Nigeria holds in Africa, its health care sector has been seen to be worsening and lacking the capability to provide accessible and affordable health care services to its citizens, especially in the rural areas of Nigeria (Osain, 2011:470). Although, the Nigerian health care sector has encountered several outbreaks of infectious diseases, mass chemical poisoning, the health system lacks the ability to provide mechanism to combat infectious and chronic diseases. Moreover, there is an inequitable distribution of health care providers between the rural and urban areas in addition to the shortage of health care providers in Nigeria (Osain, 2011:470). The research conducted by WHO (2013:124) reveals that Nigeria has 4 physicians, 16.1 nursing and midwifery personnel, 0.2 dentists, 1.0 pharmacist, 0.3 environment and public health professionals, 1.4 community health workers and less than 0.05 psychiatrists per 10,000 populations.

Due to the outbreak of diseases and inequitable distribution of health care providers, and the lack of health care providers in the rural areas to provide care and cure for illness, WHO (2013:51-56) estimates the life expectancy at birth in Nigeria to be 52 years for males and 54 years for females. In contrast, the life expectancy at birth in France is shown to be 78 years for males and 85 years for females, Canada reveals 80 years for males and 85 years for females and Senegal shows 60 years for males and 62 years for females. These differences among these countries and Nigeria prove that the health system in Nigeria needs to be improved (WHO, 2013:51-56).

Furthermore, Obansa and Orimisan (2013:223) report that in the Nigerian health care sector, there are shortages of competent health care providers, high level of absenteeism by health care providers in the public health institution, wrong diagnoses of diseases by unqualified health care providers, discriminatory distribution of health care providers and a sizeable number of physicians in the

public health institutions. Obansa and Orimisan (2013:223) outline other problems such as the of lack of access to finance and start-up capital for the development of health institutions by private health institutions, poor remuneration packages of health care providers, consistent strikes by public health care providers and high emigration of health care providers abroad.

Similarly, Ejumudo (2013:41) and WHO (2009:4) maintain that the health care sector in Nigeria is burdened with challenges such as, dilapidated health care facilities, obsolete medical equipment, increased cost of health care services in the private health institutions and low usage of medical insurance scheme to cover health care service costs, weak referral linkages between the levels of health systems and the outbreak of diseases and the absence of an integrated system to prevent and combat diseases. Furthermore, rural dwellers in Nigerian are unable to access health care services because there is a shortage of drugs and supplies, an importation and proliferation of fake and an adulterated drugs in the country, inadequate supervision by health and safety regulatory bodies, a pervasive corruption by health and safety regulatory officials and unregulated competition between private health institutions (Uneke, Ogbonna, Ezeoha, Oyibo, Onwe & Ngwu, 2007:1). According to Uneke *et al*. (2007:1), other challenges in the Nigerian health care sector include poor quality of health care services provided by public health institutions, varying quality of health care services provided by the private health institutions, poor education and communication on health and sex education in the rural areas, cultural and religious beliefs against the use of health institutions, low level of political commitments in the health care sector and low expenditure made by the government on the health care sector.

Considering the size of Nigeria's population and the government’s failure to cater for the health care needs of its citizens, many public and private health care providers have spurred the development of privately-owned hospitals. The provision of the costly health care services by private health institutions can only be afforded by clients that are ready to pay in cash or can be gained through financial support from the community or family members (SHOPS Project, 2012:4). The challenges in the public health sector have spurred the development and rapid growth of the private health sector and the private health institutions provides 65% of health care services

with a wide range of quality health care services to the majority of Nigerian citizens (Gustafsson-Wright & Schellekens, 2013:8). Since the private health institutions provide health care services that are expensive the majority of the private health institutions are located in the urban areas populated by clients that can pay for these health care services (SHOPS Project, 2012:4). Thus, purchasing health care services has become a burden and a disadvantage to the low income citizens in the rural areas of Nigeria (Olakunde, 2012:6). Nevertheless, Gustafsson-Wright and Schellekens (2013:8) report that rural and urban Nigerians have no options to utilise the costly private health institutions in order to meet their health needs.

3.3 THE STRUCTURE OF THE NIGERIAN HEALTH CARE SECTOR

The structure of the Nigerian health care sector is complex which indicates that, the provision of health care services is done by a wide range of providers in the public and private health care sector. The private and public health institutions are particularly responsible for delivering health care services to Nigerians (Olakunde, 2012:5).

Basically, the traditional and orthodox healing are two types of healing methods or health care services that are delivered in Nigeria. The orthodox health care delivery method in Nigeria is provided by the public and private health care sector. The orthodox method of healing uses westernised knowledge, practises, organisation and social roles of westernised culture in delivering health care services and healing to Nigerians (Osemene, Elujoba & Ilori, 2011:280-281). The traditional health care delivery method uses the old-age method of healing and cure, based on the socio-cultural, religious knowledge, history, attitudes and beliefs of clients. The traditional health care delivery method is done by private health providers (traditional practitioners) in the private health care sector in which herbs, animal parts and mineral substances are used to provide health care and healing to Nigerians (Etobe & Etobe, 2013:23; NCH ADOPTED, 2009:15).

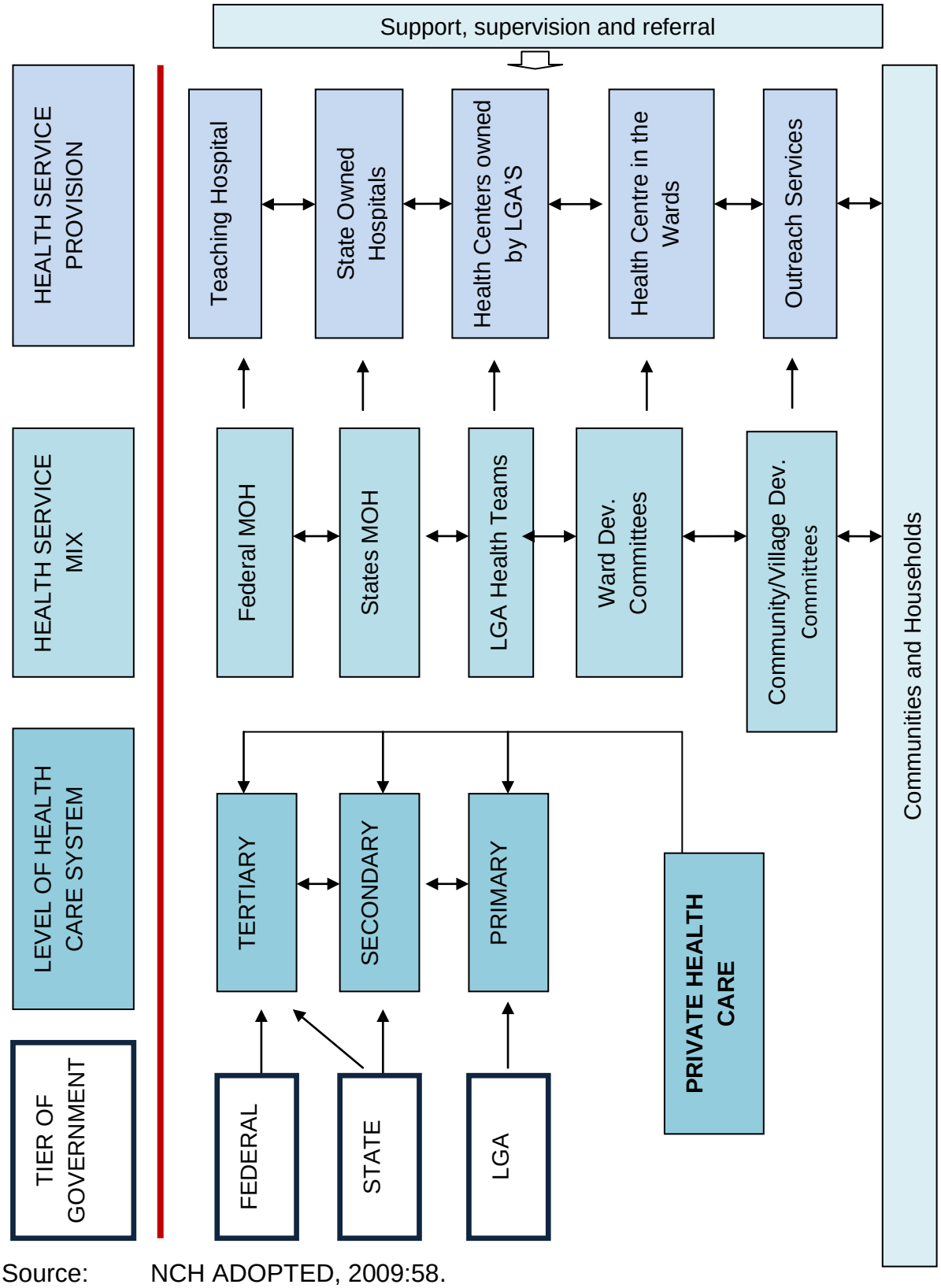
Furthermore, major providers of health care services in the private health care sector include for profit and non-profit private health institutions such as, informal health care providers, Faith-Based organisations (FBOs), private health institutions and

traditional health care providers (Olakunde, 2012:5). The public health care sector offers health care services that are provided by the three tiers of the Nigerian government through the Federal Ministry of Health (FMOH), State Ministry of Health (SMOH) and local government health authorities (LGA). The public health care sector operates on three levels of the health system, namely, tertiary, secondary and primary (Federal Ministry of Health Abuja, 2004:10). The Nigerian private health care sector, however, offers health care services through the private health institutions, FBOs, informal health care providers and traditional practitioners at the tertiary, secondary and primary level of the Nigerian health system (SHOPS Project, 2012:3).

According to NCH ADOPTED (2009:58), Figure 3.1 reveals the levels of the Nigerian health system. Figure 3.1 shows the three tiers of Nigerian government (federal, state and local). Figure 3.1 as presented by NCH ADOPTED (2009:58) reveals that the federal government concerned itself with the tertiary level of health system, the state is responsible for providing health care services at the secondary level and the local government (LGA) is responsible for the provision of primary health care (PHC) at the primary level of the health system. Furthermore, Figure 3.1 reveals the health service mix. This indicates that, the government acts through the ministry of health to provide health care service. In other words, the federal government provides health care services through the Federal Ministry of Health (FMOH) in teaching hospitals, state government provides health care services through the State Ministry of Health (SMOH) in state owned hospitals and the local government provides health care services through local government area health teams (LGA health teams) in health centers owned by the local government. Furthermore, Figure 3.1 shows that the ward development committees and community/village development committees act under the local government to provide primary health care services to community and households in health centre in the wards and outreach services.

Furthermore, the private health care sector as depicted in Figure 3.1 provides a wide range of health care services at the tertiary, secondary, primary level of the health system to all Nigerians. Figure 3.1 shows the level of the Nigerian health care system.

Figure 3.1: Levels of health care in Nigeria



Source: NCH ADOPTED, 2009:58.

According to the Federal Ministry of Health Abuja (2004:12-13), Figure 3.1 reveals the three levels of health care in the Nigerian public and private health care sector. In this chapter, the levels of health and the functions of government at each level (federal, state and local) in the public and private health care sector will be discussed.

3.3.1 Public health care sector

The public health care sector delivers health care services that are limited to the affairs of the federal ministry of health, state ministry of health and the local government. The Federal Ministry of Health Abuja (2004:12) attributes separate responsibilities of the national health system that are organised into the primary, secondary and tertiary levels. NCH ADOPTED (2009:58) suggests that the levels of health care in the public health care sector consist of three levels namely, the federal government, the state government and local government.

3.3.1.1 The federal government level

The federal government through the Federal Ministry of Health (FMOH) is responsible for the tertiary level of the health system. The Federal Ministry of Health is concerned with the provision of health care services through the teaching hospitals, tertiary hospitals, federal medical centers, National eye centers and national laboratories. These public health institutions provide specialised health care services for the treatment of rare diseases or specific disease conditions or specific group of clients that are referred from the primary and secondary level (Federal Ministry of Health Abuja, 2004:12). Specifically, the Federal Ministry of Health (FMOH) concerns itself with the regulation, support and supervision of the entire health system, development and implementation of policy, standards, health plans and programmes, inter-national relations on health matters and the national health management information system (Olakunde, 2012:5).

3.3.1.2 The state government level

The state government through the State Ministry of Health (SMOH) provides the secondary level of health care services that is available at the district, division and zonal level. The secondary level of health system provides specialised health care services to out-patients and in-patients through hospitals and community health services. Basically, the out-patients and in-patients that are referred by the primary health care level to the secondary health care level are offered specialised medical services such as surgery, pediatrics, obstetrics and gynecology (Chankova, Nguyen, Chipanta, Kombe, Onoja & Ogungbemi, 2006:3). Furthermore, the state government is responsible for regulating the activities of the local government level (primary health care services) which provides technical support such as diagnostic, blood bank, laboratory rehabilitation, and physiotherapy to the primary health care level. The secondary health care facilities (general hospitals) are staffed by medical officers (physicians), nurses, midwives, laboratory and pharmacy specialists and community health officers (Federal Ministry of Health Abuja, 2004:12).

3.3.1.3 The local government level

The provision of the primary health care (PHC) is solely the responsibility of the local government and it acts through the Local Government Area health teams (LGA health Teams) with the support of the state government within the overall national health policy. The primary health care service provided by the local government is the entry point of the health system for all Nigerians. The local government provides general primary health care services that are organised through the health centers, clinics, dispensaries, health posts and wards (Olakunde, 2012:5). The health care services provided by the primary health care centre seek to prevent and cure illness, promote and restore wellness for all Nigerians. Primary health care service at the local government level is staffed by nurses, Community Health Officers (CHOs), Community Health Extension Workers (CHEWs), junior community health extension workers and environmental health officers (Chankova *et al*., 2006:3). Furthermore, the community is the most crucial link of the delivery of health care services. The community/village development committees provide support to the local government level by implementing the primary health care services at community level. The ward

development committees and community/village development committees through health centres in the ward to provide outreach health care services to communities and household. The community relates to community participation by individual and families that take control over their health and take actions in preventing diseases and seeking health care in the event of illness (NCH ADOPTED, 2009:43).

3.3.2 Health regulatory bodies

The Nigerian federal government acts through certain health organisational agencies or health regulatory bodies to provide health care services. Major health regulatory bodies set up by the federal government of Nigeria includes the National Primary Health Care Development Agency (NPHCDA) and National Agency for Food and Drug Administration and Control (NAFDAC).

3.3.2.1 National Primary Health Care Development Agency (NPHCDA)

NPHCDA (2012) reports that the federal government of Nigeria under the Federal Ministry of Health (FMOH) established the National Primary Health Care Development Agency (NPHCDA) to ensure that primary health care services, with major focus on the local government level, is accessed by all Nigerians. NPHCDA was established in 1992 and later merged with the National Programme on Immunization (NPI) in 2007. The goal of NPHCDA is to help control diseases that can be prevented, improve the access to primary health services, improve the quality of health care, strengthen the public health institutions, develop a high-performing and empowered healthy workforce, strengthen partnership and engage communities. According to NPHCDA (2012), the National Primary Health Care Development Agency also provides policy and guidance in terms of technical assistance to the state government and local government level of health system. This indicates that, the National Primary Health Care Development Agency provide training assistance to health care providers, they develop and advance public health facilities and provide recommendation on health policy and governance issues.

3.3.2.2 National Agency for Food and Drug Administration and Control (NAFDAC)

NAFDAC (2010) states that the federal government of Nigeria under the Federal Ministry of Health set up the National Agency for Food and Drug Administration and Control (NAFDAC) to control and regulate all affairs relating to the importation, exportation, advertisement, distribution, sales and use of drugs, food, cosmetics, medical devices, chemicals and packaged water. The establishment of NAFDAC in 1993 was inspired by the World Health Assembly in 1988 to combat the threat posed by counterfeit drugs and food globally. According to NAFDAC (2010), the National Agency for Food and Drug and Administration and Control acts to regulate the sudden increase of counterfeit and poor quality of drugs, register and inspect goods (food, cosmetics and drugs) produced and imported in the country, inspects factories used for the production of food, cosmetics and drugs, and conduct appropriate test to ensure that all goods produced comply with standard specification in Nigeria. In order to function effectively NAFDAC maintains close relationship with other national and international health regulatory organisations such as, the National Drug and Law Enforcement Agency (NDLEA), World Health Organisation (WHO) and United Nations International Drug Control Programme (UNIDCP).

3.3.3 Private health care sector

The private health care sector plays a crucial role in the delivery of health care services in Nigeria. Specifically, the private health care sector consists of all private health care service providers (registered and unregistered) that deliver health care services for profit and non-profit purposes (Johnson & Stoskopf, 2010:308). According to Johnson and Stoskopf (2010:308), the private health sector in collaboration with the public health care sector is responsible for providing health care services at the tertiary, secondary and primary level of health system in Nigeria. Johnson and Stoskopf (2010:308) and RAND Europe (2009:83) state that the registered private health care providers are regulated and monitored by the federal government through the Federal Ministry of Health (FMOH), State Ministry of Health (SMOH) and other health regulatory bodies whilst the unregistered private health care providers perform their business activities outside the health system that is monitored, controlled and organised by the government.

Furthermore, the private health care sector in Nigeria provides a wide range of health care services with varying quality levels to 65% of Nigerians (Gustafsson-Wright & Schellekens, 2013:8). The private health institutions are situated mostly in the urban areas in Nigeria which are highly concentrated with citizens that have the financial ability to pay for health care service delivered (SHOPS Project, 2012:4). However, IFC (2008:8) argues that despite the disparities that exist in the location and utilisation of private health institutions, numerous Nigerians located in the rural areas still utilise the private health institutions.

The cost in purchasing health care services in private health care sector is hardly afforded by majority of Nigerians and the cost of health care services is expensive for clients that can afford it (Federal Ministry of Health, 2005:15). Furthermore, to make payments for health care services delivered in the private health institutions, clients either utilise the faith-based health facilities where health care service cost is subsidized or utilise the for-profit private health institutions where full cost of health care services is paid for. Most often, clients make immediate payments for health care services purchased through immediate cash payment or financial support from family or friends (SHOPS Project, 2012:3). Furthermore, there are several types of private health care providers in the private health care sector in Nigeria such as, private health institutions, traditional medicine practitioners, informal health care providers (Patent Medicine Vendors or drug sellers) that are for profit purposes and the non-governmental health care providers such as the Faith-Based Organisations (FBOs) that are not necessarily for profit purposes (Dutta, Kariisa, Osika, Kombe, Onoja, Muhammed, & Oyemakinde, 2009:11). The following health care providers in the private health care sector will be discussed.

3.3.3.1 Faith-Based Organisations (FBOs)

The Faith-Based Organisations (FBOs) in Nigeria are religious or charitable organisations that provide health care services to the masses mostly in the rural areas and few in the urban area in Nigeria. These Faith-Based Organisations are mostly affiliated to the Catholic Church in Nigeria and few Islamic-based organisations in the northern area of Nigeria (Dutta *et al*., 2009:12). According to Kagawa, Anglemyer and Montagu (2012:1) and Hippolyte, Phillips-Caesar, Winston,

Charlson and Peterson (2013:1), Faith-Based Organisations (FBOs) are religious organisations that play an important role in strengthening the health system and they ensure the development and implementations of strategies to prevent disease, promote health and ensuring that health care services is accessed in developing countries.

Similarly, Bielefeld and Cleveland (2013:468-469) report that Faith-Based Organisations exist in large numbers in the USA and they provide a variety and considerable amount of social services such as, health care services and various forms of aid to the poor, rehabilitation of criminals and substance abusers, employment support and advocacy, education and special services for immigrants. Furthermore, the research carried out by Kagawa *et al*. (2012:4) affirm that Faith-Based Organisations provides health care services and essential heath infrastructure to the underserved and low-income earners in many African countries. Specifically, Kagawa *et al*. (2012:4) reveal that the FBOs such as, Christian Health Associations (CHAs) concerns itself with numerous health programmes and health care services in Africa and it provides 40% of hospitals in Tanzania, 44% of hospitals in Rwanda, and 36% of health care services in Benin.

Furthermore, Faith-Based Organisations, such as, National Religious Association for Social Development (NRASD) in South Africa, Catholic Relief Services Madagascar (CRS) founded by Catholics bishops of the United States, Churches Health Association of Zambia (CHAZ), Istiqama (local mosque) in Zanzibar, Kwai River Christian Hospital (KRCH) and Norwegian Church Aid (interfaith Faith-Based Organisations that consist of sixty Buddhist, Muslim, Catholic and Protestant) in Thailand are all Faith-Based Organisations that strengthen the health system by providing food, financial aid, drugs, care and support, prevention and treatment of diseases, supportive environment and TB/HIV collaborative activities in and outside their countries (The Global Fund, 2010:5-10; 2008:8-10).

3.3.3.2 Traditional medicine system

The traditional medicine system of health care services is an alternative or optional health care service that is associated with the beliefs and cultures of many Nigerian citizens. Due to the importance and preference of the age-old traditional medicine, numerous Nigerians patronise the traditional means of health care service for wellness purposes (Ogunbekun, Ogunbekun & Orabaton, 1999:174). In other words, the traditional or alternative health care providers, provide health care services to clients whose preference is the traditional method of healing for wellness (NCH ADOPTED, 2009:15; Ogunbekun *et al*., 1999:174). Furthermore, WHO (2000:1) states that the traditional medicine system has a long history and its use in healing and wellness is based on the tradition, beliefs and knowledge in different cultures.

WHO (2000:1) further reports that the use of traditional medicine varies amongst countries and regions, as it is affected by factors such as the history, personal attitude, philosophy and the culture of the people. The term 'traditional' medicine is also referred to as alternative, complementary and non-conventional medicine and it is the use of herbs such as, flowers, leaves, roots, seeds, stems, wood, bark and other herbal materials for the maintenance of the body, prevention of diseases, diagnosis and treatment of physical and mental illness (WHO, 2000:1-3). According to the International Bioethics Committee (2013:4), the use of traditional medicine for treatment and wellness purpose can be divided into three, namely, medication therapies using herbal medicine, non-medication therapies using manual (massage, meditation, religious and spiritual) and mixed therapies (combination of medication and non-medication therapies. IBC (2013:5) states that the use of traditional medicine is recognised as a part of the health system of several continents.

Specifically, in the Middle East, the traditional medicine system is referred to as the Islamic traditional medicine and it a form of ancient Hippocratic medicine developed by Muslim herbalist, pharmacologist, chemist and physicians for the use of healing and herbal medication. Traditional medicine in Asia and the pacific is highly recognised and acknowledged in their health system. The Chinese and Indians embrace the traditional medicine system and regard it as a therapeutic approach for restoring harmony and balance to the human body. Basically, 60% of the curriculum

in the traditional Chinese medical school is devoted to traditional medicine and 40% to modern medicine (IBC, 2013:4).

Furthermore, in Europe and North America, modern medicine is mostly used in their health system, although citizens also utilise the traditional means of treatment for healing and wellness purpose. In order to promote the traditional medicine system, several traditional medicine practitioner associations have been established in the United Kingdom, Ireland and Denmark. These associations joined the European Herbal and Traditional Medicine Practitioners Association (EHTPA) in 1993 to gain official recognition and legalisation throughout the European Union (IBC, 2013:8).

IBC (2013:5) reports that the use of traditional medicine in numerous African countries is the primary source of health care. The traditional medicine healers in Africa are often regarded as powerful persons with spiritual connections and they provide health care services and restore wellness by using plants, minerals and animal parts and procedures such as spiritual and ritual actions to restore health. According to Dada, Yinusa and Giwa (2011:263), numerous Nigerians utilise the traditional means of health care services and healing because of the cultural beliefs, fast services, cheaper payment, easy accessibility, pressure from friends and families and preference for the use of incantations and concoction. The traditional health practitioners and other alternative health providers at the primary level are referred to as the “front line” health care providers by the federal government. They are encouraged and supported by the Federal Ministry of Health (FMOH) for the provision of primary health care for many Nigerian citizens that prefer the traditional means of wellness (Federal Ministry of Health, 2005:16). Thus, the federal government of Nigeria incorporated the practise and use of traditional medicine with the orthodox medicine in the 2004 health policy (Federal Ministry of Health Abuja, 2004:12&25).

3.3.3.3 Informal health care providers

The preference of self-medication has increased the utilisation of private health care services from informal health care providers such as, Patent Medicine Vendors (PMVs) and unlicensed drug sellers popularly called “chemist” in Nigeria (Olike, 2007:3). According to Goodman, Brieger, Unwin, Mills, Meek and George (2007:203), informal health care providers are prevalent in many Sub-Saharan African countries such as, Cameroon, Tanzania, Uganda, Kenya, Togo and Nigeria. These informal health care providers are also referred to as chemical sellers, Patent Medicine Vendors (PMVs), medicine sellers, drug sellers and they are known for providing health care services in rural and urban areas, mostly for the treatment of malaria and fever (Goodman *et al*., 2007:204).

Furthermore, numerous Nigerians perform self-medication by consulting medical advise and treatment from informal health care providers that operate in the private health care sector (Olike, 2007:3). According to Okeke, Uzochukwu and Okafor (2006:1-2), rural and urban Nigerians prefer the use of Patent Medicine Vendors because of the cost of medicine and flexible pricing policies, shorter waiting time, availability of drugs, geographical accessibility, longer opening hours, confidentiality and their friendliness with clients. Similarly, Goodman *et al*. (2007:203) report that the informal health care providers are highly patronised for the provision and supply of cheap drugs due to the consistent stock-out of drugs in public hospitals. Faster service, deferred payment, cheaper consultation fees and proximity to homes are other reasons why the informal health care providers are patronised.

Furthermore, Goodman *et al*. (2007:204) report that numerous drug sellers carry out their business activities in kiosks, market stalls, shops and can be found hawking. Olike (2007:15) affirms that these informal health care providers have their businesses located in open market, general stores and can be found hawking in street or selling in buses. Medicines are sold by these people on credit, at cheaper prices and without a doctor’s or pharmacy’s prescription.

In Nigeria, the informal health care providers sell orthodox or westernised medicines and sometimes administer treatments (injections and intravenous drip) in a manner

that is not regulated. Bloom, Standing, Lucas, Bhuiya, Oladepo and Peters (2011:146) state that the informal health care providers are informal health care practitioners that provide a variety of health care services without the possession of a medical certificate which is required by the health regulatory authorities. Goodman *et al*. (2007:204) confirms the occurrence of this practise by stating that the informal health care providers that are prevalent in Cameroon, Nigeria and Tanzania have little knowledge and formal training in the field of medicine and, as a result, handle and keep drugs in inappropriate ways, administer treatment without proper diagnosis of illness, provide inaccurate advise on the in-take of medicine and stock the most sought-after drugs purchased by clients.

Nevertheless, Kapoor, Ranman, Sachdeva and Satyanarayana (2012:1) state that in the treatment of tuberculosis, the low income citizens and rural community in India sought wellness from the informal health care providers (Patent Medicine Vendors/unlicensed drug sellers). Furthermore, Sudhinaraset, Ingram, Lofthouse and Montagu (2013:1) confirm this practise by stating that the unlicensed drug sellers provide health care services particularly to the poor. Sudhinaraset *et al*. (2013:1) characterise the unlicensed drug sellers on the basis of four criteria, namely, training (no formal training), payment (receive immediate payment from patient), registration and regulation (not registered with any government/health regulatory body) and professional affiliation (if any exists, they conduct minimal self-regulation and are focused on networking and business activities). According to Kapoor *et al*. (2012:3), 62% of patients in Delhi India sought the unlicensed drug sellers as their first choice of the treatment of tuberculosis and 30.6% consulted a qualified health care provider for health care services. Similarly, research findings by Ogah, Madukwe, Onyeonoro, Chukwuonye, Ukegbu, Akhimien and Okpechi (2013:64) in Table 3.1 indicate that a large number of Nigerians situated in Abia State sought informal health care providers (chemist) for medication and health care services.

Table 3.1 reveals the care-seeking behaviour of respondents.

Table 3.1: Care-seeking behaviour of respondents

Place of primary care	(n=957)
Chemist	714
Clinic	118
Health center	48
Self-medication	42
Laboratory	9
Prayer house	9
Invites a (family) care provider-doctor/nurse	10
Herbalist	2

Source: Ogah *et al*., 2013:64.

The informal health care providers also known as the Patent Medicine Vendors (PMVs) that operate in the private health care sector are major providers of health care services in urban and rural Nigeria. The informal health care providers can either operate as an unlicensed or licensed health care provider. This indicates that, the informal health care providers can be unlicensed to operate their business as without adhering to the policies provided by the ministry of health or can be licensed to operate under the regulations of the National Association of Patent Proprietary and Medicine Dealers (NAPPMED) set up by the Federal Ministry of Health (FHI 360, 2013:1). However, the Patent Medicine Vendors (PMVs) under the regulation of the National Association of Patent Proprietary and Medicine Dealers (NAPPMED) are referred to as the frontline health workers licensed to perform consultation, treatment and sell orthodox or westernised medicines (Berendes, Adeyemi, Oladele, Oresanya, Okoh & Valadez, 2012:2; FHI 360, 2013:1). Thus, the Patent Medicine Vendors (PMVs) under the regulations and supervision of the Federal Ministry of Health are also encouraged and urged to provide improved quality of primary health care services in line with the current policy on PMVs (Federal Ministry of Health, 2005:16).

3.3.3.4 Private health institutions

The private health institutions are formal health care providers of health care services in the private health care sector. They are responsible for providing a range of varying health care services at the tertiary, secondary and primary level of health system in Nigeria (NCH ADOPTED, 2009:58). Furthermore, private health institutions are mostly owned and managed by individual doctors (sole proprietorship) that provide general medical care to clients. Individual doctors that serve in the private health institution also request the service of other specialised doctors to provide medical support to clients. Further, health care providers from the public health care sector are also involved in managing and providing health care services in the private health institutions that are either owned by them or recruited by other private health care providers to work for certain hours a week (Dutta *et al*., 2009:14).

In addition, the forms of private health institution facilities in Nigeria includes clinics, cottage hospital, dispensary, health centre, health clinic, health post, hospital, maternity, secondary hospital, primary health center and basic health clinic (Dutta *et al*., 2009:14). Approximately, 70% of all secondary facilities and 35% of primary health care facilities in Nigeria is owned and managed by the private health institutions (Malaria Operational Plan FY, 2013:13).

According to the Federal Ministry of Health (2005:16), the private health institutions at all levels of the health system shares the responsibility of the public health care sector by providing primary health care that is preventive, promotive and curative for all Nigerians. Due to this, the federal government created a partnership with the private health care sector (public-private partnership) to enhance the accessibility, affordability, equitability, sustainability and quality of health care services for all Nigerians (Federal Ministry of Health, 2005:8).

The federal government of Nigeria encourages the private health care providers (for-profit and non-profit) to provide clinical services and non-clinical services at all levels of the health system on their own or in a partnership arrangement between the public and private players (Federal Ministry of Health, 2005:16). Although, the private

health care sector in Nigeria is covered by the private health care providers, such as, the informal health care providers (drug sellers or Patent Medicine Vendors), traditional practitioners, Faith-Based Organisations and private health institutions, the main focus of this research study is the utilisation of health care services from the private health institutions.

3.3.3.5 Challenges in the private health care sector

The private health care sector is a significant player of health care delivery in Nigeria. The private health care sector addresses the challenge that is faced by the public health care sector in terms of the delivery of quality health care services. Despite the role that the private health care sector plays in the Nigerian health care sector, they are faced with numerous challenges that weaken their effort in providing accessible and affordable health care services (Barnes, Chandani & Feeley, 2008:12). These challenges affect the economy of the country. For example, poor access to health care services by the country's work force can become a personal and societal cost for the country. When the majority of Nigerian citizens, as a result of poverty or non-access to health care, cannot meet their need for wellness, it is likely that there will be an increase in the mortality rate or an outbreak of diseases. This plague may become a problem for the society and, in turn, increase the personal cost of citizens and societal cost to combat the disease (AHRQ, 2009). According to Barnes *et al*. (2008:12), factors that are responsible for constraining the provision of health care service provided by the private health care sector in Nigeria are the lack of access to loan, poor infrastructure, poor regulation, lack of medical equipment and low skilled personnel.

The provision of quality and affordable health care services has become a difficult challenge for the private health institutions. Private health institutions lack business development support services and adequate funding or do not have access to loans from financial institutions to finance and grow their business. Investors are reluctant to invest in the private health care sector and the few investors that are willing to invest, request high surcharges and mark-ups to cover the risks involved (Kimberley, 2009:1). Numerous private health institutions also find it difficult to develop their business, purchase medical equipment and hire highly qualified health care

providers because they are financially under-served by the Nigerian financial institutions (SHOPS Project, 2012:5). The lack of access to finance from financial institutions sector restricts the private institutions from purchasing costly medical equipment. Johnson and Stoskopf (2010:310) confirm this finding by stating that, the medical equipment used by private health institutions are obsolete and need to be replaced. However, replacing the equipment demands financial loan and cooperation from financial institutions. In other words, the lack of finance and access to credit encourages numerous private health institutions to utilise medical equipment inappropriately and under invest in medical supplies, instruments and equipment. Even so, cash payments made by clients for health care services are used by private health institutions to purchase substandard medical equipment (Barnes *et al*., 2008:12).

The significant role that the private health institutions play in delivering quality health care services to Nigerians is affected by poor and costly facilities. Since the majority of private health institutions lack access to funds, they tend to utilise facilities that are relatively cheap and affordable. Furthermore, when facilities are leased and purchased at a high cost, private health care providers are likely to increase the cost of health care service to make up for the cost of the service facility purchased or leased. The disadvantage associated with the poor and costly infrastructure in Nigeria has discouraged many private health institutions from starting a private practise but it rather encourages them to travel to developed countries in search of a better job (Uneke *et al*., 2007:1).

Moreover, the private health care sector in Nigeria includes all private health care providers that are poorly regulated. The federal government through the ministry of health provides policies that guide and monitor the activities of the private health care sector. Despite the policies provided, numerous private health care providers such as Patent Medicine Vendors (PMVs), private health institutions and traditional medicine practitioners remain unlicensed and perform business activities outside the control of the ministry of health (Johnson & Stoskopf, 2010:308). However, the poor regulations in the private health care sector led to the federal government establishing health regulatory organisations to set up new rules and regulations in

the reformed health policy that guide the operations of the private health care sector at all levels of the health system (Federal Ministry of Health, 2005:18).

In spite of the rules, the activities of the private health care sector remain poorly regulated as far as pricing (high prices are set at their own interest for profit making), medical equipment (less standardized equipments are utilised for delivering health care services), quality assurance (varying health care services amongst the rich and poor) employment of unqualified health care providers and use of expired drugs. This challenge in the private health care sector has led to price wars, increased competition, and varying levels of quality of health care services that affect the accessibility and affordability of health care by all Nigerians (Federal Ministry of Health, 2005:18).

The availability of skilled personnel such as doctors, nurses, laboratory and pharmaceutical staff in the private health care sector is significant in delivering quality health care services and in achieving the best health outcomes. The unregulated private health care sector in Nigeria is flooded with low skilled personnel that are not properly trained in the field of medicine (National Human Resources for Health Strategic Plan, 2007:12). Low-skilled personnel in the private health care sector can be found amongst the informal drug sellers and the patent medicine vendors. They have less knowledge about medicine and operate without formal training in numerous pharmacies (Okeke *et al*., 2006).

Numerous low-skilled and inexperienced nurses/midwives that operate in the private health institutions also administer wrong treatment on clients and low skilled laboratory staff performs wrong diagnosis of disease. The low productivity and performance of these low-skilled workers in the private health care sector have become a challenge that raises the mortality rate of Nigerian citizens (Dutta *et al*., 2009:36). As a result, the National Human Resources for Health Strategic Plan mapped out strategies to tackle the crisis of human resource sector in the Nigerian health care sector. One of the key policy objectives of the National Human resources for Health Strategic Plan is to ensure that the health care providers are properly trained (pre-service and in-service training) and are skilled to deliver quality health

care services to all Nigerians (National Human Resources for Health Strategic Plan, 2007:8-10).

3.4 REFORMATION IN THE NIGERIAN HEALTH CARE SECTOR

The challenges that exist in the health care sector propelled the Nigerian federal government to initiate a reformation in 2004 to combat the problems and meet the health care needs of all Nigerian citizens (Uneke, Ezeoha, Ndukwe, Oyibo & Onwe, 2013:542). Reformation refers to an incremental and positive change or an evolutionary change directed at improving the effectiveness and efficiency of the health care sector. It is a change that is continuous instead of being once-off (Berman & Bossert, 2000:2). Reformation is directed at tackling the deficiencies in the health care sector and to create a turnaround in the health care sector in order to promote the achievement of the overall health policy objectives and improve health outcomes (Cassels, 1995:331). The reformation of the health care sector is expected to go beyond the redefinition of the overall health policy objectives to encompassing a total change in the structure of the health care sector. The structural change becomes the change in the existing organisational structures and management systems and style (Cassels, 1995:331). Therefore, the health care sector reform is defined as the continuous or sustainable process of refining policies, defining priorities and reforming the health institutions (organisational or structural change) through which these refined policies will be implemented (Cassels, 1995:331). Similarly, Uneke *et al*. (2013:542) describe the reformation in the Nigerian health care sector as a sustained process of fundamental change in policy regulation, financing, health care provision, management structure and institutional arrangement that is led and designed by the government to achieve better health outcomes for all Nigerians. Thus, the reformation in the health care sector is guided by the government so that the health system and well-being of its citizens is improved.

3.4.1 Reasons for reformation in the health care sector

In a developing country such as Nigeria, Cassels (1995:330) and Roberts, Hsiao, Berman and Reich (2002:8) suggest that a reformation in the health care sector is needed to identify and manage problems such as, rising cost, limited capacity to pay, the inefficient use of scarce resources, inaccessible health care service and when the health care services does not respond to the health need of the population.

(a) **Rising cost**: A reformation is needed in the health care sector when there is an increase in the cost of health care services in the private and public health institutions. According to Huber (2003:2), the rising cost of health care services is a result of the outbreak of new diseases, aging population, invention of new drugs, expensive and quality medical equipment used in delivering quality services and the demographics of clients. The demand for quality health care services increases when the country is populated by the old, rich, intelligent and secular. This means that a high demand for health care service drives the cost of health care services up (Huber, 2003:2). Due to the rising cost in health care services, several countries are beginning to change their health policies and approach to make the health system accessible to and affordable by the poor.

(b) **Limited capacity to pay**: A reformation in the health care sector is needed when the majority of the population has a limited capacity to pay for health care services. The limited capacity to pay is a result of the poverty level of the population and the increase in the cost of health care services in the private health care sector (WHO, 2000:5). WHO (2000:5) reveals that poverty is related to worst health outcomes. This indicates that, the presence of poverty hinders access to costly quality health care services and lack of access can bring about ill health, increase the spread of diseases and increase the mortality rate of children and adults.

(c) **The inefficient use of scarce resources**: The government needs reformation in the health care sector when public funds are not channelled into the health care sector and the unallocated budget is shared or spent

inappropriately on government officials (Cassels, 1995:330). Thus, it is important that government reforms the organisational or management structure and regulatory bodies (Ejumudo, 2013:41).

(d) **Inaccessible health care service**: When the majority of a country's population cannot access quality health care services due to location, gender, lack of employment and the nature of job, the unavailability of health care service to treat rare diseases, poor management of health institutions, it is crucial for the government to reform the health care sector (Cassels, 1995:330).

(e) **The health care services that are provided do not respond to the health needs of the population**: The health system of any country is effective when the health needs of its citizens are met. According to WHO (2009), the public health care sector in Nigeria is crippled by numerous challenges that make it unable to meet the health needs of its citizens. Patients are often faced with escalating problems such as low population coverage with unequal access to adequate health care services, absence of clean water and sanitation, lack of technology to deliver effective services and inadequate health information systems to monitor and analyse health indicators.

Consequently, these challenges motivated the Nigerian federal government, through the Federal Ministry of Health (FMOH), to initiate a reformation in the health care sector. According to Obansa and Orimisan (2013:225), the reformation in the Nigerian health care sector is necessary to increase the strategies of tackling the challenges and achieving the health policy objectives. In order to create a positive and sustainable change in the health care sector, the Nigerian federal government put forward the Health Sector Reform Program (HSRP) from 2004-2007. The HSRP set up certain objectives, targets and priorities relating to health and health care in Nigeria. These would function as guidelines that the Federal Ministry of Health (FMOH), the State Ministry of Health (SMOH), local government and the private health care sector would follow (Federal Ministry of Health in Abuja, 2004:6).

The new national health policy was formulated within the context of the National Economic Empowerment and Development Strategy (NEEDS), Millennium Development Goals (MDGs) and the New Partnership for Africa's Development (NEPAD) (Federal Ministry of Health Abuja, 2004:5). The overall objectives and implementation of the health care sector reform program was put forward as a strategy to address problems in the health care sector, strengthen the role of government in the health care sector and improve the quality, affordability and accessibility of health care services to achieve better health outcomes for all Nigerians (Federal Ministry of Health Abuja, 2004:6). According to the Federal Ministry of Health Abuja (2004:6), the federal government of Nigeria asserts that the reformation of the health care sector is aimed at reducing, by two-thirds, the mortality rate and morbidity rate of infants under five years of age between 1990 and 2015, reducing by three-quarters the maternal mortality rate between 1990 and 2015, halting and reversing the spread of HIV/AIDS by 2015 and halting and reversing the incidence of malaria and other major diseases by 2015.

In addition, the reformed health policy was developed to address the management of the national health system, the burden of disease, the mobilisation and utilisation of health resources, health service delivery, consumer awareness and community involvement, partnership, collaboration and coordination of the health system (NCH ADOPTED, 2009:2). According to NCH ADOPTED (2009:2) and Obansa and Orimisan (2013:228), the Health Sector Reform Program (HSRP), approved by the federal government, have recorded a number of policy and legislative initiatives such as the following:

(a) **Strengthening of the National Health Bill**: The health bill that provides or enforces a law regarding the formulation and implementation of the structure of the health policy in 1988 was strengthened in 2004. The current health policy addresses the issues brought by NEEDS and the MDGs programme. It also shows and divides the responsibility of the primary health care service delivery between federal, state and local government.

(b) **Launching of the National Health Insurance Scheme**: The National Health Insurance Scheme (NHIS) was introduced to improve the universal

access to quality health care services and improve the quality of health care for all Nigerians. The introduction of NHIS is aimed at avoiding the financial constraints or difficulties associated with unforeseen and chronic illnesses.

(c) **Strengthening and developing diseases programmes**: In order to combat and reduce the spread of disease, the federal government through several health organisational bodies has introduced several programmes. Such programmes as the National Tuberculosis and Leprosy Control Programme (NTBLCP) at all state level, the development of cost medium-term strategic plans for National Program on Immunization (NPI) to fight against polio, the development of National Action Committee on AIDS (NACA) to fight, support and focus on people living with HIV/AIDS, National Contraceptive Logistic Management System (CLMS) and the National Malaria Control Program (NMCP) to control malaria were developed by the government.

(d) **Improvement of the delivery of primary health care services**: The federal government strove to improve the delivery of quality primary health care services through the support of the National Agency for Food and Drugs (NAFDAC) and the National Primary Health Care Development Agency (NPHCDA). NAFDAC is increasingly fighting to reduce the surge and importation of adulterated drugs into the country. NPHCDA provides guidance and technical assistance to local and state government for the implementation of primary health care. They strive to reduce the maternal mortality rate by addressing the shortage of skilled health care providers, training of health care providers and improvement of the primary health facilities and medical equipments (public health institutions).

(e) **Review of the national health policy**: The national health policy has been reviewed by the federal government and was formulated within the context of NEEDS, NEPAD and MDGs to better meet and satisfy the health needs of all Nigerian citizens. The main focus of the national health policy is the national health system and management, national health care resources, national health interventions, national health information system, partnership for health development, health research and national health care laws

(Federal Ministry of Health Abuja, 2004:7). The review of the national health policy gave rise to the development of a collaboration between the public and private health care sector (Public-Private Partnership) so that health care can be affordable, accessible and equitably distributed to all Nigerians (Federal Ministry of Health, 2005:8).

Although the provision of high quality and affordable health care services might be a challenge for the federal government, a sustainable reform, strong political, social and economic support can create a positive change in the health care sector. Furthermore, achieving the health policy objectives means that sufficient public revenue is allocated to the health care sector, the public fund is equitably distributed and resources are utilised efficiently for health gains (Obansa & Orimisan, 2013:235).

3.5 ASSESSMENT AND COMPARISON OF THE HEALTH SYSTEM OF NIGERIA AND FRANCE

The World Health Report, on the comparison of health systems published by the World Health Organisation (WHO) in the year 2000, has generated high interest amongst countries. It has also been utilised by numerous countries to introduce a better way of improving efficiency, enhancing the performance of their health system, reducing cost and improving the quality and delivery of health care services (Smith & Papanicolas, 2012:2). Smith and Papanicolas (2012:8) state that the performance measurement of health systems evaluates and reveals the extent to which a country meets or achieves the objectives of its health system. According to WHO (2000:8), an improvement in the health system does not necessarily connote achieving improvement in the health system but in providing total, accessible and affordable health care services and responding to the health needs of the citizens. In other words, WHO (2000:8) reveals three main objectives of a good health system which are: to provide good health (improvement in the health of the population), responsiveness to the expectations of the population and fair financial contribution (provision of financial protection against the cost of sickness).

The operations, regulations and activities of the health system of numerous countries are not similar in terms of the social, cultural, political and economic setting. Differences in the health systems of numerous countries also exist in the size, form of financing and service provision, institutional arrangement and structure. Due to the differences that exist in the health system, the health care services delivered and the performance outcome of the health system (good or poor) vary across countries (Dean & Fenton, 2010:1; Johnson & Stoskopf, 2010:5). In order to explain the performance outcome (good or bad) of a health system of a country WHO (2000:xi) states that the manner in which a country carries out certain functions, namely, services provision, resource generation, financing and stewardship needs to be critically evaluated.

Nevertheless, the World Health Report did not only provide an assessment and performance measurement of a country's health system, it revealed a global ranking that ranked each member country's overall health system performance on the basis of the level of health, fair distribution of health, level of responsiveness, the distribution of responsiveness and fairness of financial contribution (WHO, 2000:149). Amongst 191 member countries that were assessed, the first three health systems that ranked highest were France, Italy and San Marino, whilst Nigeria ranked 187th position (WHO, 2000:153-156).

Furthermore, the World Health Report published in 2000 was an advantage to numerous countries in that reforms were introduced to enhance and improve the performance of the health system. However, it also became a disadvantage, as it raised issues such as policy misconception, criticism over the factors WHO used for performance measurement, fierce political debate over ranking one country globally above others and WHO's challenge in carrying out an extensive and complex research on comparison (Brown, 2002:190; Smith & Papanicolas, 2012:2). Due to this, the World Health Organisation only provides continuous assessment, observations and detailed description of health systems and decline providing publication on global ranking on health systems performance since the year 2000 (Boerma, Chopra & Evans, 2009:2).

Notwithstanding changes in the performance outcome, and improvements must have taken place in the health system of these countries over the years, the country (France) with the highest health system ranking will be discussed and will be used to benchmark the health system of Nigeria so as to improve the performance outcome and quality of service delivered in the Nigerian health system (Smith & Papanicolas, 2012:4).

3.5.1 The health system of France

The Central Intelligence Agency (2013) reports that France is the largest west European nation with a population of 66 million and a population growth rate of 0.47%. According to the CIA (2013), France is diversified across many sectors and amongst these sectors is the health care sector. The health care sector of France according to WHO (2000:153) was ranked number one in the global health ranking of overall health systems performance.

Furthermore, health care services in France are provided by the university hospitals owned by the government and private for-profit clinics owned by individuals or large corporations. Numerous private health institutions are approved by the France government for the provision of health care services and they also work for the National Health Service of France (Thomson, Osborn, Squires & Jun, 2012:41). The French government through the Ministry of Health (MoH) provides health policy, manages resources, regulates the quality of health care services, the health care expenditure and the health system. Specifically, the state government provides training for health care providers, monitors safety and oversees the social protection of all citizens (Civitas, 2013:2).

The health system of France is largely controlled by the government and it provides universal coverage or social security (sécurité sociale) for all citizens through the Statutory Health Insurance (SHI) funds to all citizens based on employment (employed or self-employed), benefits (unemployed) and as a student or retired person (Thomson *et al*., 2012:39). Thomson *et al*. (2012:39) report that the introduction of Universal Medical Coverage (Couverture Maladie Universelle or CMU) in the year 2000 have provided medical coverage for citizens that are not

eligible for SHI, visitors from within the European Union (EU), illegal residents that applied for residency and non-EU visitors are covered for emergency only.

Specifically, SHI provides medical coverage such as rehabilitation and psychotherapy, diagnostic services, drug prescription, hospital and ambulatory care by general practitioners, specialist, dentist and midwives. SHI also provides free mammography and colorectal cancer screening for patients over 50 years old, HPV immunization for adolescent girls, immunization for citizens over 65 years of age, people with chronic diseases, pregnant women and infant. Furthermore, the complimentary Private Health Insurance (PHI) also provides medical coverage to 95% of citizens for medical cost excluded or not covered by the SHI through their employers or means-tested vouchers (CMU complémentaire or CMU-C). However, Statutory Health Insurance competes with the non-profit PHI in providing private health insurance through employers or means-tested vouchers (CMU-C) (Thomson *et al*., 2012:39-41).

Furthermore, provision of funds in the health system of France is largely provided by the central government and partly by means of health contributions (payroll contributions and earned mark tax) of employers and employees and it is managed by the Ministry of Health through the national programme of social health insurance (NHI) (Civitas, 2013:1). Specifically, the France health system delivers quality health care services from government hospital (university hospitals) funded by 90% SHI, 7% PHI and 3% clients' personal payment (Thomson *et al*., 2012:41).

In order to reduce the challenge of immediate and personal payment of health care services and the longer waiting time on the filling of medical forms, the France government introduced the 'Carte Vitale'. Citizens and non-citizen residents that will be in France for more than three months are issued the Carte Vitale upon registration with the Caisse Primaire d'Assurance Maladie (CPAM) for national health insurance coverage (Civitas, 2013:3). The Carte Vitale is an electronic card that offers a patient a national insurance right to French insurance. It has health insurance information about a patient in electronic form. The Carte Vitale enables patients to receive direct reimbursement in their bank accounts within five days by the government for treatment and medicines covered by the SHI. In other words,

health care services charged on the patients Carte Vitale is immediately reimbursed by the patient state health insurance provider (Civitas, 2013:3).

The world health report by WHO (2010:ix) states that the health system of a country is said to have attained universal coverage when its citizens are not financially constrained to using health care services and there is access to health care service that is preventive, promotive, rehabilitative and curative. Evidently, the world health statistics by WHO (2013:134) reports that the government of France spends 11.7% of GDP on health and it provides 95.3% universal coverage (social security) expenditure on health to its citizen. Thus, the universal coverage that the government offers to the citizens and non-citizens of France enables easy access to health care service by all citizens irrespective of gender, social class and age.

Furthermore, Pelletier-Fleury and Le Vaillant (2013:4) state that the health institutions of France deliver excellent health care services to patients and there is a good relationship between the health care providers and patients. According to Pelletier-Fleury and Le Vaillant (2013:4), 80% of respondents affirmed that there exist a good relationship between patients and health care providers, patients are well informed about the medical decision and 75% of patients affirmed that the health care service they received was excellent. Due to the excellent and easy access to health care service, Table 3.2 reveals, the life expectancy at birth, for French citizens, is 82 years, whilst Nigeria is 56 years.

Table 3.2 as presented by WHO (2013: 52-137) shows the comparison of the health outcome of France and Nigeria. The percentages between the health outcome of France and Nigeria reveal a wide gap between the health care providers, life expectancy at birth and government expenditure on the health system. In other words, Table 3.2 reveals that the health system of France is more improved than that of Nigeria. WHO (2000:40) reports that an improvement in a country's health outcome implies that the government spends more of a given income on the health system than others, it responds to the health need of its citizens and there is an equal distribution of the health care service between the poor and rich. Thus, insights into the health system of France will be an example that will show reasons why the

Nigerian government needs to assist the public and private health institutions and increase expenditures made on the health care sector.

Table 3.2 shows the comparison of the health system and health outcomes of France and Nigeria.

Table 3.2: Comparison of the health outcomes of France and Nigeria

Health outcome	France	Nigeria
Physician per 10,000 population	33.8	4
Nursing and midwifery per 10,000 population	93	16.1
Dentist per 10,000 population	6.4	0.2
Pharmacist per 10,000 population	11.5	1
Psychiatrist per 10,000 population	2.2	<0.05
Under five mortality rate per 1000 births	3%	124%
Maternal mortality ratio per 100,000 live births	8%	630%
HIV infection per 100,000 population	255%	2095%
Contraceptive prevalence	77%	14%
Population using improved drinking-water sources	100%	50%
Population using improved sanitation	100%	10%
Births attended by skilled health personnel	98%	34%
Antenatal care coverage	99%	45%
Life expectancy at birth (Both gender)	82 years	56 years
Total expenditure on health as % of GDP	11.7%	5.4%
Social security expenditure on health as % of general government expenditure on health	95.3%	0%
Private expenditure on health as % of total expenditure on health	23.1%	68.5%
Out-of-pocket expenditure as % of private expenditure on health	32.2%	95.6%

Source: WHO, 2013:52-137.

3.6 STRATEGIES FOR AN EFFECTIVE HEALTH SYSTEM

The federal, state and local government of Nigeria is committed to providing quality health care service that is accessible to all Nigerians in the rural and urban areas. Duru and Nwagbos (2007:1) state that the public health care sector has failed to provide accessible health care services to citizens in the urban and rural area. Furthermore, the quality of health care services delivered in the public health

institutions is less than what Nigerians expect. Since the challenges in the public health care sector have weakened the effort of the governments' provision of affordable and accessible health care services, an effort was made by the federal government of Nigeria to partner with the private health care sector. In other words, the Public Private Partnership (PPP) between the private and public health institutions is a collaborative relationship and strategy that is aimed at optimising the use of available resources, knowledge and facilities in promoting efficient, effective, affordable, and accessible health care services for all Nigerians (Federal Ministry of Health, 2005:8).

The partnership between the public and private health care sector has been able to address the challenges associated with inaccessible and affordable health care services. Irrespective, Obansa and Orimisan (2013:234) postulate that the Nigerian government must tackle other challenges to enable health care services for all citizens to be accessible and affordable.

According to WHO (2013), in order to have an effective and strengthened health system the Nigerian government should address the challenges related to health care providers, infrastructure, medical equipments and medicines, logistics, tracking progress and effective financing. However, in addressing all major constraints in the health system, Obansa and Orimisan (2013:234) advise that the federal government should seek out and employ the use of several strategies to improve the health system for all Nigerians. According to Abdulraheem, Olapipo, and Amodu (2012:8), Obansa and Orimisan (2013:234) and Uneke *et al*. (2013), the strategies that the Nigerian federal government can utilise in creating an effective health system are:

(a) **Strengthening the health management information system**: The Nigerian federal government should put in place information facilities such as functional internet, computers and printers at all levels of health care facilities that will help health care providers to conduct research associated with health and wellness. Accurate and up-to-date information gathered from research can assist health care providers and policy makers in health planning, monitoring the health status of the population, disease prevention and providing evidence upon which policies can be made. Adequate

information facilities put in place can help health care providers to have an accurate record keeping when tracking the progress of recovery for out-patients and in-patients and strengthen clients information system (Makinde, Adebayo, Adeleke, Ohadi, Dieng & Osika, 2012:xi; NCH ADOPTED, 2009:41). Makinde *et al*. (2012:17) support this notion by suggesting that the federal government should endeavour to train health care providers on the use of information devices to reduce client waiting time and develop e-Health policies that encourages the storage, transmission and use of electronic data in health institutions.

(b) **Strengthening community participation and involvement in health care**: Health care at the community level is the most crucial link of the delivery of primary health care services. Therefore, in ensuring an effective primary health system at community level, the local government should ensure an equal distribution of sufficiently trained health providers in the rural and urban communities (NCH ADOPTED, 2009:32). Since individuals and families assume responsibility for their own health and well-being at community level, it is important that the Federal Ministry of Health, through the health care providers, train, communicate and educate community members about health education and involve them in health programmes. Successful implementation of health care services at community level can reduce the spread of disease and improve the overall health status of Nigerians (Abdulraheem *et al*., 2012:9).

(c) **Strengthening and improvement of health institutions**: In order to ensure that the health care sector is effective, the three tiers of government should ensure that the public and private health institutions are equipped with quality medical equipment and facilities for the delivery of health care service and emergencies. Furthermore, the government should establish a specific standard of health facilities and medical equipment for both the public and private health institutions. A system through which these facilities are maintained at all levels of health system should be put in place (NCH ADOPTED, 2009:26). According to WHO (2013), to improve the health institutions of the country, the government should ensure a consistent supply

and availability of medicine at all public health institutions in the urban and rural areas in Nigeria.

(d) **Strengthening health and safety regulatory bodies**: Health and safety regulatory bodies such as NAFDAC monitor the import, export and supply of foods, medical products and cosmetics within country and ensure the safety in the consumption of all food and medical supply. In order to have an effective health system and avoid the rise of mortality rate through the importation and consumption of fake supplies of all food and medical supplies, the Nigerian government should standardise and regulate the practise of all health regulatory bodies (Diugwu, Baba & Egila, 2012:145). This indicates that, certain operational guidelines should be put in place by the government. This would compel health regulatory bodies to perform their duties by ensuring the flow of high quality food and medical supplies. In this manner, health regulatory bodies such as NPHCDA should ensure strict compliance and regular monitoring of all players (public and private) in the health care sector and ensuring that they are properly aligned to meet the Primary Health Care (PHC) needs of all Nigerians (NCH ADOPTED, 2009:27).

(e) **Provision of an attractive and supportive environment for health care providers and investors**: High emigration and consistent strikes of health care providers are a major challenge in the Nigerian health care sector. This challenge affects the quality of care that is received by clients. In order to address it Wiskow, Albreht and De Pietro (2010:1) suggest that the Nigerian government should provide an attractive and supportive environment that will enable supply, retention, enhancement, effectiveness, motivation and investment of health care providers in the public and private health care sector. Wiskow *et al*. (2010:5) describe an attractive work environment as the quality dimension of work that attracts, retains and enables health care providers to function effectively. Therefore, there is a need to create an attractive environment that will foster development and investment in the health care sector. The Nigerian government should employ such strategies, as improving financial benefits, bonuses and incentives, motivating and

supporting through professional development and training, providing a system that encourages a balance between family and work as well as a system for health protection due to occupational hazards (Hongoro & Normand, 2006:1310; Obansa & Orimisan, 2013:234; Wiskow *et al*., 2010:7-19). Additionally, SHOPS Project (2012:10) asserts that in order to provide an attractive and supportive environment for private health institutions, the Nigerian government should support the development of licensed private health institutions in the area of credit accessibility, training and technical assistance service. Thus, the availability and access of funds can address the challenge associated with the use of obsolete medical equipment and poor service facilities faced by the private health institutions.

(f) **Monitoring the performance and evaluation of health reforms and policies**: The reform of the health care sector is a consistent effort and continuous process that government makes to change positively and improve the delivery of health care services in Nigeria. To achieve an effective health system, policy makers and other major stakeholders and actors should have sufficient knowledge of the health care sector reforms and the process by which they are applied to strengthen the health system (Uneke *et al*., 2013:543). Furthermore, the Nigerian government should set up an agency that would track and monitor the use of resources, ensure compliance to health policies, evaluate and monitor the performances of all health institutions and health regulatory bodies (Obansa & Orimisan, 2013:234). Ensuring consistent monitoring and evaluating health reforms and policies will enable the government to address challenges related to fraud committed by health care officials, rising costs of health care services, inefficient use of resources and lack of medical supply (Cassels, 1995:330). Thus, an understanding of the health reforms will enable policy makers and government to refine policies, define new priorities based on the feedback and information gathered from continuous evaluation and monitoring exercise.

(g) **Increased financing of the health care sector**: The level of funding available in the health care sector is not proportional to the health needs of

Nigerians. Due to the low funds provided by the government, low quality of health care services is delivered to clients at all levels of the public health care sector (NCH ADOPTED, 2009:36). According to WHO (2009), health funding in Nigerian is basically a mixture of government budget, health insurance, external funding and personal income payment. WHO (2013:139) states that the Nigerian government spends 5.4% of the gross domestic product (GDP) on the health care sector and client personal income spending on health has increased from 92.7% in 2000 to 95.6% in 2013. Due to the increased payment of cash on health by individual spending, Obansa and Orimisan (2013:235) state that the Nigerian government should make an effort to increase financial investment and public spending on health so as to meet the health demands of Nigerians. Due to the financial constraint in the health care sector NCH ADOPTED (2009:36) suggests that appropriate mechanism should be put in place to stimulate the increment and allocation of public resources by 15% in the health care sector. According to NCH ADOPTED (2009:36), other financial strategies that should be employed by the Nigerian federal government in improving the health care sector include pre-payment and health insurance scheme, grants from the federal government, a proportion of Value Added Tax (VAT) from cigarette and alcohol, donations, charities and special funds gathered for the cure of chronic diseases.

(h) **Strengthening the use of insurance scheme**: Numerous Nigerians have little or no protection against financial risk and economic cost of catastrophic illnesses. This indicates that numerous Nigerians lack social health protection approaches such as social health insurance, other pre-paid schemes, and community based health insurance schemes to cover the cost of unforeseen and chronic illnesses (NCH ADOPTED, 2009:36). According to Onoka, Onwujekwe, Uzochukwu and Ezumah (2013:1), only 4% of the federal government employees are covered by the National Health Insurance Scheme (NHIS) through the Formal Sector Social Health Insurance Programme (FSSHIP). In spite of the small percentage of citizens covered, several measures have been put in place by the Nigerian government to achieve a wider insurance coverage for all Nigerians by 2015.

In order to address the challenge associated with Nigerians' inability to cope with financial risk, NCH ADOPTED (2009:36) states that the Nigerian government needs to review and amend the current law establishing the NHIS to provide legislative backing for its regulatory authority. Similarly, Onoka *et al*. (2013) say that policy makers and implementers should consider the disadvantages associated with using public funds for a universal coverage that first focuses only on government employees. Furthermore, the use of public funds may potentially compromise the availability of financial risk protection measures to other Nigerian citizens. Dealing with this potential compromise, will strengthen the capacity of NHIS in the provision of an effective social health insurance protection against financial risk associated with chronic and unanticipated illness for all Nigerians (NCH ADOPTED, 2009:36).

(i) **Political support and commitment in the health care sector**: The Nigerian health care sector is a labour intensive sector that requires collaboration amongst policy makers, private health care sector, government, NGOs, regulatory bodies and political support. The Nigerian health care sector is in a deplorable state because of the political negligence at lower levels of the health system (NCH ADOPTED, 2009:19). Abdulraheem *et al*. (2012:10) report that enhanced political commitment and support are vital for achieving preventive and accessible health care services and tackle inequalities that exist in the provision of health for all Nigerians. Political support and commitment in the health care sector will provide ground upon which a policy can be formulated and implemented to ensure that the health needs of Nigerians are met.

3.7 SUMMARY

The Nigerian health care sector comprises health care providers, institutions and resources whose aim is to promote, restore and provide health care services to all Nigerians in accordance with the health policy. The effectiveness of the health care sector is crucial for the development of the Nigerian economy. The public and private health care sector in Nigeria is responsible for the delivery of health care services, especially, the provision of health care in the public health care sector which is basically the responsibility of the federal, state and local government. The private health care sector comprises several private health care providers, such as, Patent Medicine Vendors (PMVs), private institutions, Faith Based Organisations (FBOs) and traditional medicine practitioners that provide health care services for profit and non-profit purposes at all levels of the Nigerian health system. Furthermore, the Nigerian health care sector is faced with several challenges that make it difficult for the public and private health care sector to provide accessible and affordable health care services for all Nigerians.

This chapter discussed the assessment and comparison of the health system of Nigeria and France. The statistics of health outcomes and health system of Nigeria and France revealed differences in percentages which showed that the health system and outcome of France was better than that of Nigeria. However, the comparison of the health system of France was utilised as a benchmark of improving the effectiveness of the Nigerian health system. The result was that, increased participation of the community, well-structured collaboration of private and public health care sector, consistent reformation, monitoring and evaluation of the performance based on health reforms and policy as well as an increased political and government commitment would address the challenge and make health care service accessible and affordable for all Nigerians.

The following chapter will discuss the model for consumer decision-making process of private health institutions in Nigeria. The modelled influences of the consumer decision-making process will be discussed. The decision-making process as well as the buying process for services and modelled outcomes of the decision-making process will be discussed.

CHAPTER FOUR
A MODEL FOR CONSUMER DECISION-MAKING PROCESS OF PRIVATE HEALTH INSTITUTIONS

4.1 INTRODUCTION

The utilisation of health care services by all citizens of a country is paramount for the growth and development of an economy. The government, health institutions and health regulatory bodies have a crucial role to play in improving and providing access to affordable and quality health care service to the citizens of a country (Mahmud & Parkhurst, 2007:8). Numerous researchers agree that the utilisation of affordable and quality health care service provided by the health care sector to all citizens of a country can help achieve the objectives or policies aim at promoting the general health and well-being of the work force, tackling and eradicating poverty and boosting the economy of a country (Tamsma & Berman, 2004:5-18). Moreover, the utilisation and access to health care services in the private health institution can bring relief to illness and improve the health of citizens (Gulliford & Morgan, 2013:1). Gulliford and Morgan (2013:1) further argue that access to health care services means that basic health care services are available to all citizens despite their disparity in socio-economic status.

In spite of the importance of accessibility and utilisation of health care services in the private health institution, numerous clients still lack access and experience restriction in the utilisation of health care services. The previous chapter assessed and discussed the overview of the health care sector in general and the Nigerian health care sector in particular. The purpose of this study is to investigate the influencing factors of the consumer decision-making process regarding the utilisation of the private health institution. This chapter will provide discussions on the theoretical model formulated to achieve the objectives and purpose of this study. The theoretical model was constructed on the basis of individual determinants of health service utilisation posited by Andersen and Newman (2005:14) and the buying process for services put forward by Boshoff and Du Plessis (2009:63).

The independent variables in this study comprise predisposing and enabling factors, the mediating variable is the consumer decision-making process, and the dependent variables are customer satisfaction and cognitive dissonance. Furthermore, a comprehensive discussion based on each factor that affects the client's utilisation of health care services will be provided and the hypotheses formulated for each variable and attributes will be presented.

4.2 THE MODELLED INFLUENCES OF CONSUMER DECISION-MAKING PROCESS

The consumer (client) decision-making process is a problem solving process that is followed by clients in order to satisfy their need for wellness (Lantos, 2010:66). Numerous clients perform an intensive search for information from several sources and thereafter make a decision to purchase health care services from an evoked set of several private health institutions (Haksever & Render, 2013:46).

Mullins *et al*. (2008:98) report that despite the similar process that clients go through in purchasing health care services, they end up making different decisions regarding the choice of health institutions. Two clients for example, can have similar health care needs and follow a similar decision-making process in order to make choices regarding a health institution but both clients can end up making different decisions regarding the utilisation of health institutions (private health institution (home or abroad) or public health institution). Williams (2005:34) is of the opinion that the differences in the decisions made by clients are often influenced by several factors which affect their utilisation and access of the health institution.

Williams (2005:34) suggests that a clients' decisions to access health care services and utilise health care institutions are influenced by factors such as, environmental factors, nature and structure of the health care system, economic factors (population characteristics and individual attributes that relate to financial wealth and level of insurance coverage) and communication factors (language barriers and inability of the society to communicate their health needs effectively). Furthermore, Williams (2005:35) maintains that clients' attitudes regarding the utilisation of and access to health care services, social structure, occupation education, ethnicity, cultural

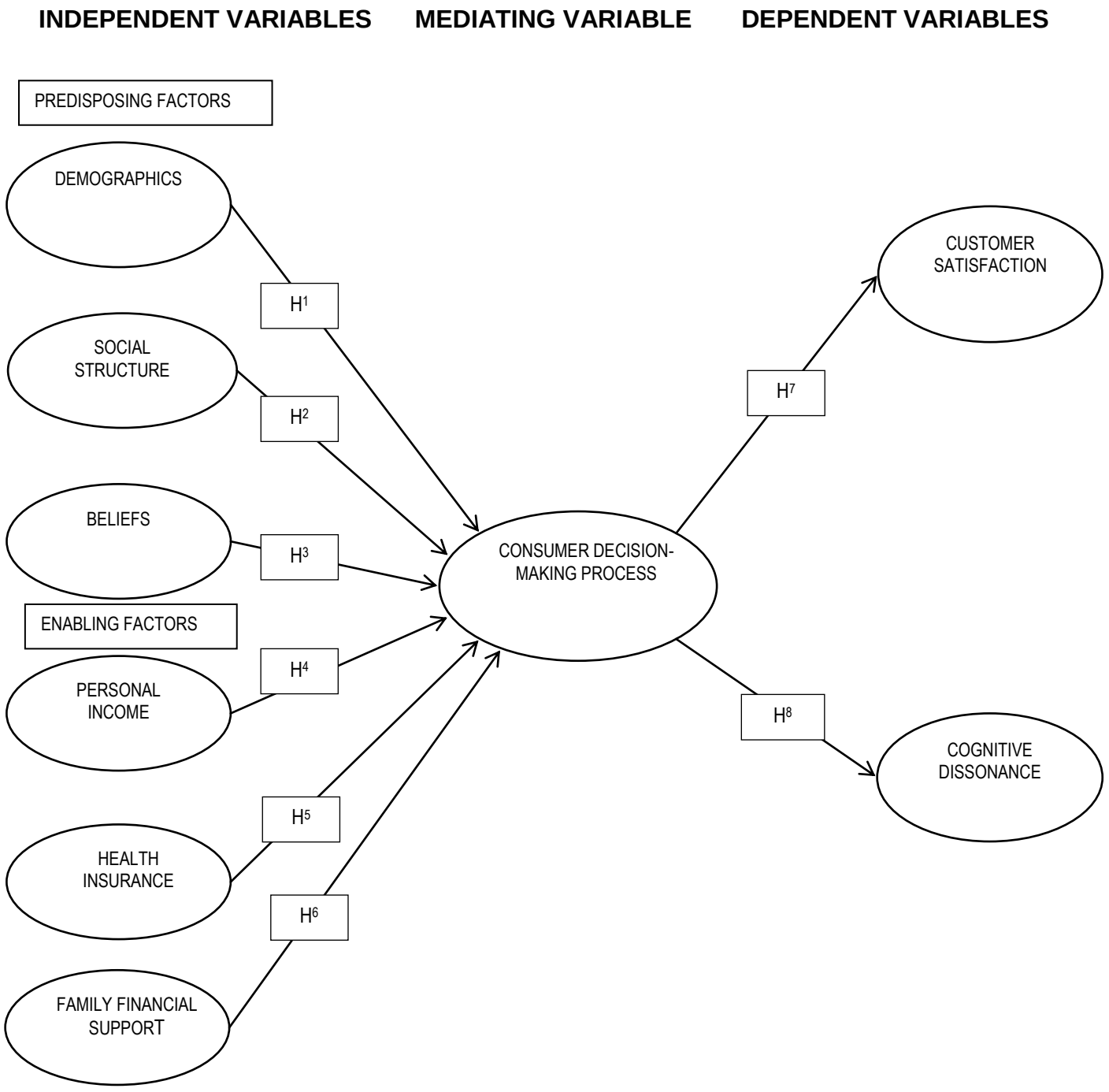
attitudes and beliefs relating to values, knowledge and attitudes from past experience, are factors that affect how clients will respond to their health needs and how they access and utilise health care services from private health institution.

According to Kotler and Keller (2011:172), the factors that influence the clients' decision-making process regarding the utilisation of health institution are the cultural, social and personal factors. In a similar vein, Andersen and Newman (2005:2) view the utilisation of health care services as a type of individual behaviour that is affected by factors such as societal determinants (technology and norms), individual determinants (predisposing factors, enabling factors and illness level) and health services system (resources and organisation). Specifically, on the individual determinants, Andersen and Newman (2005:14) report that the factors that influence the client decision-making process regarding the utilisation of health institutions are a function of the clients' predisposing characteristics, enabling characteristics and illness level.

Andersen and Newman (2005:12) further explain that the predisposing, enabling and illness level factors are individual characteristics of clients that influence and determine the type and level of health care services they receive. In other words, these factors influence how a client utilises health care services, it determines the volume of health care services that is utilised and their ability to purchase the health care services (Andersen & Newman, 2005:2).

Figure 4.1 illustrates the theoretical model of the factors influencing the consumer decision-making process regarding the use of a private health institution. Figure 4.1 shows the modelled influences on and the outcome of consumer decision-making. Figure 4.1 reveals that the predisposing factor (demographics, social structure, health beliefs) and enabling factor (individual income, health insurance and family financial support) are the independent variables that will influence clients' decision-making process regarding the utilisation of a private health institution.

Figure 4.1: The modelled influences and outcomes of consumer decision-making process on private health institutions



4.2.1 Predisposing factors

The decision taken by clients to utilise a health institution differs and is determined by the clients' characteristics under the predisposing factor. A client's education (knowledge about health care service) or occupation influences their decision-making process regarding the utilisation of private health institutions (Andersen & Newman, 2005:15). Furthermore, the predisposing characteristics of a client determine how frequently a client seeks health care services from a private health institution. In other words, a client with a high level of education and awareness of medicine is likely to seek health care services more frequently (routine check-ups) than a client who is an illiterate or one who is not knowledgeable about the consequences of diseases, medicine and wellness. Similarly, Lo and Fulda (2008:2) state that the predisposing factors are individual characteristics that may increase the possibility of a client to utilising more health care services.

4.2.1.1 Demographics

Grd-Hansen, Olsen and Sørensen (2012:136) posit that clients' personal characteristics such as the age, gender and marital status will influence their decision to utilise health care services and the frequency in which the health care service is utilised. Similarly, Wilson, Kratzke and Hoxmeier (2012: 25-28) report that gender, age, family, income, education and insurance are factors that act as impediments to clients' utilisation of health care services in the private health institution. This indicates that the demographic characteristics such as the client's age (all ages) will determine how frequently a client can have access to a private health institution and how frequently a client needs or requires the health care services of a private health institution.

(a) **Age** is a crucial factor that influences the utilisation of health care services. Research shows that a population that has the highest percentage of old age clients usually accounts for the biggest share of a nation's health care service cost as compared to a population with younger people. Liu, Tian and Yao (2012:253) suggest that the age of clients determines the health seeking behaviour of clients and as a result of the age, the need for health

care services is likely to increase or reduce the utilisation of health care service. Liu *et al.* (2012:253) further argue that clients that are 65 years of age and above are likely to increase the demand on health care services to satisfy their need for wellness.

The empirical findings of Ergano, Getachew, Seyum and Negash (2012:118) reveal that age has a significant influence on the utilisation of health care services. According to Ergano *et al*. (2012:118), young educated mothers are more likely to utilise health care services from health institutions for child delivery than older mothers. According to McNamara, Normand and Whelan (2013:3), the utilisation of health care services rises as clients get older. In other words, clients are more likely to seek and utilise health care service as they get older. In addition, McNamara *et al*. (2013:3) report that in Ireland clients from the ages of 80 and above have the highest percentage of utilisation of health care services from a general practitioner. This indicates that the need and utilisation of health care services increases as the age of a client increases.

In the Nigerian health care setting, age and gender are referred to as important demographic variables based on demographic classification. The utilisation of health care services regarding private health institution in Nigeria is often influenced by the age and the geopolitical zones of clients. According to the geopolitical zone in Nigeria, the younger northern mothers are not always inclined to utilise health care service for antenatal or postnatal during pregnancy and child delivery (Nigeria Demographic Health Survey (NDHS), 2008:132).

The NDHS (2008:132) findings further reveal that mothers that are young in age from South West Nigeria utilise more health care services than young mothers from North West Nigeria. The research conducted by Yar'zever and Said (2013:7) reveal that the utilisation of the place of delivery for uneducated and inexperienced young rural mothers is high for home delivery than in government health institutions. They rarely use private health institutions and in some remote areas they still prefer a traditional birth

attendants places. Furthermore, the empirical findings of Omonokpono and Odimegwu (2014:4) reveal that a higher number of young women utilise health facility for delivery. This indicates that utilisation of health care services in private health institution is affected by age and also by the geopolitical zones of clients.

(b) **Gender** as a demographic factor influences the utilisation of health care services regarding private heath institutions. Gender is referred to as what the society believes about the suitable roles, rights, responsibilities, opportunity and accepted behaviours of people on the basis of their gender which is classified into two categories (male and female) (Singh, Bloom & Brodish, 2011:5).

Numerous research findings reveal that gender disparity have an effect on health outcomes. The gender disparity is reflected in the ability or inability of women to make decisions about the utilisation of health care services and health institutions due to finance, cultural beliefs, and attitudes (Singh *et al*., 2011:7). In other words, the decision to utilise health care service regarding private health institution is often influenced by the male figure. Men are inclined to make decisions about the utilisation of health institutions and health care services for the entire family due to his level of income (financial capability to pay for such health care services) and his authority or position as the decision-maker in the house. Singh *et al*. (2011:10) further report that few women in Nigeria actually participate in decision-making regarding the utilisation of health care services and the choice of health institution.

Similarly, Buor (2004:381) states that a positive correlation exists between gender and the utilisation of health care services. Furthermore, Redondo-Sendino, Guallar-Castillón, Banegas and Rodríguez-Artalejo (2006:155) suggest that the utilisation of health care services differs according to the health needs of both gender. Redondo-Sendino *et al*. (2006:155) further argue that females have a higher need for the utilisation of health care services than males due to their greater morbidity and disability problems that they seek to resolve. Furthermore, the need for health care services for

females varies at different stages in life. In other words, the need for utilisation of health care services arises for a woman as they get older. There is an increase in the use of health care services during and after child birth, gynecological health care services and a greater need of health care services in an advanced age (Redondo-Sendino *et al*., 2006:155).

(c) **Marital status** influences a clients' decision to purchase health care service. Kotler and Keller (2011:178) stipulate that new needs crop up as clients pass through different stages in life. In other words, the health need of a female client that is single (unmarried) will be different from her health need when she is married and pregnant. Furthermore, clients that are married with children are likely to make decisions routinely to access and utilise health care services for themselves or for their children. Whilst clients that are married without children will only make decision to purchase health care services for their well-being. In other words, clients with children will habitually make decisions to purchase health care services, such as, maternity or pregnancy checkups, vaccination for children, home health attendant and family planning whilst the reverse is not the case for married clients without children (Kotler & Keller, 2011:178).

According to Manzoor, Hashmi and Mukhtar (2009:101), the marital status of clients have a significant relationship regarding the utilisation of health care services and the selection of health institutions. Similarly, Iwashyna and Christakis (2003:2143) argue that the change in marital status leads to differences in the utilisation of health care services and the level of care that is received by a client. According to Iwashyna and Christakis (2003:2143), the early widowed are likely to visit and receive more frequently health care services from a private health institution due to sicknesses arising from shock or loss of partner than clients whose spouse is still alive. Furthermore, Reynolds, Wong and Tucker's (2006:9) empirical findings indicate that in the area of marital status and gender, young single females are less likely to visit health institutions and utilise health care services than married females. In other words, the married female seek more health care services than before,

during and after child birth (prenatal care postnatal care and child care) to avoid the negative consequence associated with pregnancy and child birth.

Due to the evidence that has been presented, it is seen that demographics (age, gender and marital status) under the predisposing factor influences the utilisation of health care services regarding private health institution (Christiansen, Bech, Lauridsen & Nielsen, 2006:23). Therefore, It is hypothesised that:

H^1: *There is a positive relationship between demographics and consumer decision-making process in a private health institution*.

4.2.1.2 Social structure

Social structure comprises attributes such as education, occupation, family size and religion. The attributes of the social structure that a client is predisposed to will influence its decision-making process regarding the utilisation of health care services from the private health institutions. The attributes of social structure will be explained for clarity purpose (Yu, 2008:19).

(a) **Education**. The lifestyle and societal status that is enjoyed by a client is determined by the level of education. According to NDHS (2008:13), the educational level of clients or the knowledge that clients have in the field of medicine and health care in general, can determine their utilisation of health care services in the private health institution. Birmeta, Dibaba and Woldeyohannes's (2013:7) empirical findings indicate that a positive relationship exists between education and utilisation of health care services regarding a private health institution. According to Birmeta *et al*. (2013:7), mothers that are educated are considered to have greater awareness of the importance and benefits of the utilisation of maternal health care. In other words, mothers with better knowledge and information in modern medical treatment utilise more of health care services and benefit from the health care services received. Lo and Fulda's (2008:1) empirical findings reveal that that children whose parents are educated and earn sufficient income tend to

utilise more health care services than children whose parents have low education and earn insufficient income to pay for health care services. Similarly, Ochako, Fotso, Ikamari and Khasakhala (2011:7) state that women with no basic education and less knowledge in medicine and health care services are likely to carry out self care and deliver at home rather than utilising health institution for child delivery.

Alguwaihes and Shah (2009:26) maintain that education is associated with the utilisation of health care services. According to Alguwaihes and Shah (2009:26), clients with high education are more likely to utilise health care services and patronise the use of a specialist whilst clients with low education are ignorant about their sickness and they are likely to decline the use of health care service or merely utilise a primary care physician for their sicknesses. Hunt and Bueno De Mesquita (2014:5) affirm that when health care services are declined or ignored, the mortality rate of clients may increase. In order to reduce the mortality rate, Hunt and Bueno De Mesquita (2014:5) suggest that health education in general and awareness of sexual and reproductive health should be taught to all citizens of a country irrespective of their biological and socio-economic preconditions.

Furthermore, NDHS (2008:18) reports that Nigerian women who have a primary, secondary or tertiary education are more likely to make a decision to utilise health care services than women with no education and knowledge of medicine. Babalola and Fatusi's (2009:9) empirical findings reveal that education is a significant predictor of health care service utilisation. This indicates that education (knowledge or awareness of disease and medication) can propel clients to make decisions to utilise health care services. Babalola and Fatusi (2009:9) further report that because better educated women in Nigeria have greater knowledge and awareness of quality health care services they are likely to make a decision to utilise quality health care service from the private health institution irrespective of the cost. Due to the influence of education on decision-making process, Babalola and Fatusi's empirical findings showed an imbalance on the utilisation of health care services across the Nigerian geopolitical zones.

Specifically, the decision to utilise health care service for purposes of wellness was significantly higher in Southern Nigeria than in Northern Nigeria. The imbalance in the decision to utilise health care services from private health institution between the Northern and Southern part of Nigeria is due to the low level of education, lack of awareness of disease and level of medication.

(b) **Occupation** is crucial in differentiating the level of clients from three perspectives, namely, income differences, career differences or employment position and uneven exposure to unemployment risks (Halleröd & Gustafsson, 2010:116). Furthermore, the differences that exist in the occupation of individuals are helpful in differentiating or distinguishing the economical class or social class of clients. The economical class and social class of clients determine the type and quality of health care services that they consume and the differences in the quality (good or poor) of health care received can be linked to the health status of a client (Halleröd & Gustafsson, 2010:117).

Larson and Halfon (2010:332) confirm that the occupation of a client will determine the level of income earned which will influence its access and utilisation of health care service from the private health institution. The level of income received as a result of the occupation will determine if the client will utilise the costly health care services from the private health institution or free health care services from the public health institution. Armstrong and Kotler (2005:151) reveal that clients' occupations will determine and influence the purchase of health care services from a health institution.

Girma, Jira and Girma (2011:89) state that there is a significant relationship between occupation and the utilisation of health care service. The significant relationship between occupation and decision to utilise health care services indicates that clients with better professional occupation or higher employment position, such as, professional executives, are likely to utilise health care services in private health institutions or travel abroad for medical treatment. However, unskilled workers such as, cleaners and gardeners may

be inclined to access and make decisions to utilise free health care services from the public health institution (Armstrong & Kotler, 2005:151).

In the Nigerian health care setting, the private health institution is the first choice of clients with professional jobs, whilst clients with unskilled jobs in the rural area practise self-treatment, patronise traditional healers or utilise the public health institution (Awoyemi *et al*., 2011:2). Therefore, it can be argued that the choice in the decision to utilise health care services is influenced by the occupation of the client. The type of occupation determines the affordability received by a client and the level of affordability influences the decision to purchase health care services from a private health institution.

(c) **Family** has been characterised as the most influencing factor regarding the decision to utilise health care services. The decision to utilise health care services is often made as a result of the family unit. In other words, the decision made regarding the utilisation of health care services is influenced by the size of the family or the life-cycle stages of the family (Armstrong & Kotler, 2005:150). The life cycle stage of the family refers to the successive stages in the family size which will influence the type and level of health care services and health institution that they require at every stage and age. The health need and utilisation of health care services, for example, of a couple with no child differs from the health needs of a family with more children. There will be an increased need for health care services as a result of the development of a family through successive stages (Armstrong & Kotler, 2005:150).

According to Chakraborty *et al*. (2003:328), clients from a large family have more medical need and are less likely to utilise health care services. The lack of medical utilisation and limited access might be due to the constraints of financial resources or to the chanelling of the available income to satisfy more pressing needs other than medical ones in the household. In other words, the volume of health care services that is utilised will depend on the

number of people that reside in a household (Tomini, Groot & Pavlova, 2012:1).

Furthermore, Gorman and Braverman (2008:1767) assert that one's family determines their overall health and well-being. Gorman and Braverman (2008:1766) investigated the effect of family structure (single parenting and parents still married and staying together), the utilisation of health care services and a child's health status. Gorman and Braverman (2008:1767) report that children from single parents have more unmet health care needs and they are less likely to receive adequate health care services than children whose parents are married and staying together. The empirical findings of Gorman and Braverman's (2008:1773) study reveal that married parent's families make a decision to provide better access to health care for their children than single parent's families. The access and utilisation of health care services by a child is made possible through the availability of financial resources pooled by both parents or it is simply earned through private health insurance from the parent's employers.

Irrespective of the family size and family structure, family attitude and experience of a particular health institution can influence their level of access, utilisation and purchase of health care services. A member of a family, for example, who experiences a bad surgical operation, wrong diagnosis or inadequacies from a particular private health institution can spread negative word-of-mouth and discourage other family members from utilising the same health institution. This action can create negative feelings and attitude amongst family members, thus influencing their decision-making to utilise health care services from the same private health institution (Robinson, Gott & Ingleton, 2014:29). Moreover, the negative feeling associated with the health care service experienced by a family member, can increase the need for health care services to be given at home by health care givers. Due to the findings presented, it can be said that family size, family structure and family experience can influence the consumer decision-making process regarding the utilisation of health care services from the private health institution.

(d) **Religion.** There has been a growing interest in research focused on the influence that the relationship between religion and the utilisation of health care services has. Prior research conducted by Benjamins and Brown (2004:110) reveal that clients that are religiously active do not always utilise health institution and are likely to spend fewer days in health institutions even if they are admitted. Clients that are not affiliated with any religion tend to make decisions to utilise the health institution more often and have a longer stay at the health institution. Moreover, the beliefs and practises of the religious group that a client belongs to may discourage the use of certain health care services, medication or treatment (preventative care such as contraceptives). Furthermore, Benjamins and Brown (2004:110) refer to religion as a predisposing characteristic because it is an individual factor that is present before the occurrence of illness and it influences the way a client accesses health care services and utilises the private health institution.

Gyimah, Takyi and Addai (2006:2941) also attest that there is a significant relationship between religion and the utilisation of health care services. Gyimah *et al*. (2006:2941) assert that while cost significantly influences the utilisation of health care services, religion has a major influence on how health care services are utilised by Christian women.

Bediako, Lattimer, Haywood, Ratanawongsa, Lanzkron and Beach (2011:121) state that the level of religious participation or involvement influences clients' ability to cope with illnesses and affects their utilisation of health institutions. In other words, clients that are highly involved in religious activities are likely to rely on and seek wellness by performing religious rituals or practises such as, prayer, meditation, consistent use of religious materials and media to cope with their illnesses. Garrido, Allison, Bergeron and Dowd (2012:318) confirms this findings by stating that religion affects clients' decision to access health care services and even when they do, they restrict themselves to certain services. Numerous clients who are affliated to religious groupings find it difficult to access certain health institutions and utilise certain health care services provided by medical practitioners. This indicates that certain health care services or types of treatment that are not

in accordance with their religious beliefs and practises are rejected and not administered on them. Religious groups such as, the Jehovah's Witness frown on the transfusion of blood at any health institution even at the point of death, Jewish and Muslims (female clients) are particular about receiving treatment from the opposite gender and Pentecostals may believe in miraculous healing whilst in the hospital (Ehman, 2012:1-5; Petrova & Clifford, 2009:36).

According to Petrova and Clifford (2009:22), the behaviour exhibited by clients as a result of their religious belief, is called conflict of duty in the provision of health care services. Petrova and Clifford (2009:22) further argue that the conflict of duty arises when health care provider refuses to administer treatment on a client because of their objection to certain health care services as a result of their religion and the gender of the health care provider. Due to the conflict that arises as a result of clients religious beliefs, Garrido *et al*. (2012:319) state that clients will make a decision to utilise health institutions that conform to their religious belief. This indicates that clients that are Muslims are likely to make favourable decisions to utilise Islamic hospitals and clients that are Roman Catholics are likely to seek and utilise health care services owned by the Catholic Church. Therefore, a client's religious beliefs and choice of health institution relating to religious affiliation encourages the utilisation of health care services from the non-profit health institutions rather than the private health institutions.

Due to the findings on the influence of social structure (education, occupation, family size and religion) on the utilisation of health care services, it is hypothesised that:

H^2: *There is a positive relationship between social structure and consumer decision-making process in a private health institution*.

4.2.1.3 Beliefs

The health beliefs that clients have can affect their health outcomes and influence their utilisation of health institutions. The perceptions, attitudes, values and knowledge that a client has toward a health institution and health care services is referred to as health beliefs (Broome & Llewelyn, 1995:3). Helman (2001) and Vaughn *et al*. (2009:65) report that there are different cultural groups with different belief systems with regards to health, sicknesses, health care services and health institutions.

Helman (2001) and Vaughn *et al*. (2009:65) state that as a result of beliefs systems, a client may attribute the cause of sickness to any of the following:

- **Individual factor**: Clients may attribute their sickness to bad habits or a negative emotional state.
- **Natural environment factor**: Clients may attribute their sickness to environmental pollution and germs.
- **Social world factor**: Clients may attribute their sickness to interpersonal stress, medical facilities, and actions of others.
- **Supernatural factor**: Clients may attribute their sickness to the purpose of a higher supernatural power.

Similarly, Ojua, Ishor and Ndom (2013:176) assert that there are diverse beliefs systems, cultural practises and religious practises relating to the utilisation of health care services and health institutions in Nigeria. The cultural beliefs, religious beliefs and cultural practises of these ethnic groups do not exclude their perception of the utilisation of health care services and health institutions. Ojua *et al*. (2013:177) and Ojua and Omono (2012:29) reveal that clients may attribute the cause of illness and seek wellness from the following:

- **Religious beliefs**: Religious beliefs are beliefs in supernatural force (God-Christians and Allah-Muslims). Clients believe that sicknesses or ill health

emanate from a good or bad supernatural force and that through meditation, fasting, praying or reading religious materials the sickness will be cured.

- **Ancestral beliefs**: Ancestral beliefs are the beliefs in ancestral and spiritual beings (witches, wizards, ancestral spirits and water spirits). Numerous clients believe that illness and other health related problems are a result of the anger of the ancestors, sins of fore-fathers and spiritual beings (water spirits). In seeking wellness, clients perform sacrifices to appease the ancestors or other spirit beings. Due to this belief, clients may await healing from ancestral powers or spirit beings and decline utilising health care services from health institutions.
- **Scientific beliefs**: Scientific beliefs explain that sickness is as a result of individual bad habits (smoking or drinking), negative emotional state, pollution, germs and stress. Due to this, clients seek wellness by utilising health care service from health institutions.

Furthermore, clients believe that their illness can be cured when they make use of complementary and alternative medicine (CAM) or traditional medicine for wellness purpose. The CAM refers to the use of herbal medicine to prevent and cure sicknesses (Gratus, Wilson, Greenfield, Damery, Warmington, Grieve, Steven & Routledge, 2009:1). According to WHO (2000:1-3), the use of traditional medicine is embedded in the history and culture of numerous African and Asian countries and it relates to the knowledge, beliefs and practises of the use of tree (herbs and minerals) and animal parts for the prevention, diagnosis, improvement of health and treatment of sicknesses.

The beliefs in the use of traditional medicine is highly recognised in numerous African and Asian countries and the types of herbs used and the way it is applied in the treatment and prevention of diseases varies across numerous countries (WHO, 2000:1). The use of the CAM is also gaining popularity in western countries (Western Herbal Medicine) in the treatment of various illnesses and preservation of good health (Smith, Priest, Carmady, Bourchier & Bensoussan, 2011:1). Due to the beliefs that the utilisation of traditional medicines will bring about wellness, clients are likely

not to make decisions to utilise the private health institution for the treatment of sicknesses.

Irrespective of the religious, cultural and traditional beliefs that clients hold about illness, treatment and utilisation of health institutions, clients form their own personal beliefs on the basis of their perceptions and past experiences of the quality of health care services that they have received from the private health institution. This indicates that clients form a negative or a positive attitude on the basis of their past experiences of services received (Wong & Haggerty, 2013:5).

Due to the personal and past experiences of the quality of health care services received by a client in either a public or private health institution, the client stores in its memory the actual and overall experiences and use them as criteria to make a general judgment on the quality that can be offered by the health institutions (Human Service, 2012:16-20). Thereafter the client is likely to form a personal belief which is based on the professionalism or superiority of the equipment, medical practitioners, environment, waiting time and quality of services that are offered by the public or private health institutions. Clients may generalise and conclude that the health institution that offered the quality of health care services that exceeds their expectation is the best (PricewaterhouseCoopers, 2012:1). Therefore, clients are likely to make decisions to consult the chemist/pharmacy or traditional healers when they belief that they can provide quicker and better health care services than the private health institutions. Wong and Haggerty (2013:4) assert that addressing and monitoring the clients' past experiences of utilising health care services can correct the perception and personal belief that a client already has about the health institution.

Moreover, clients' values and attitudes regarding private and public health institutions are important factors that influence their decision to utilise health care services. A client may a hold favourable or an unfavourable assessment, have feelings and show behavioural tendencies towards a particular health institution and its health care services. These can be very difficult to change. The perception or attitude of clients is capable of putting them into a right frame of mind in having feelings of dislike or like towards a health institution (Kotler & Keller, 2011:148).

In Nigeria, numerous clients, without having the actual experience of the use of a particular health institution, may perceive or feel that the health institution might not be able to exceed their expectations in offering quality health care services or the health institution may lack the resources in delivering effective health care services (Oluwadare, 2012:43-44). Most clients, for instance, may perceive that the private hospital does not have good medical equipment and that the public health institution has better medical equipment for surgical treatment because they are funded by the government. Other clients may believe that whilst the private hospitals have more qualified doctors, offer quality health care services, the facilities of the public health institution are not in good shape and the quality of health care services provided by the public health institution is poor. Therefore, it can be said that the utilisation of health care services from the public private health institution can be influenced by a client's personal experience, belief, perception and attitudes. Scheppers, Van Dongen, Dekker, Geertzen and Dekker (2006:326) affirm that if a client's health beliefs, attitudes, perception and expectations are not in line with a health institution, there might be a restriction in the utilisation of the health care services provided by the health institution.

Vaughn *et al*. (2009:69) suggest that it is important for health care providers to recognise the importance of clients' cultural beliefs, religious beliefs, health beliefs and attitudes, including what is acceptable and not acceptable in clients' culture. Thus, understanding clients' attitudes and perception and incorporating religious and cultural beliefs into health care services will ensure a successful and effective treatment of clients.

Therefore, it can be argued that the beliefs that arise, on the basis of a client's religion, culture, perception and attitudes from the past experiences can influence their utilisation of health care services from a private health institution. On the basis of these findings, it is hypothesised that,

H^3: *There is a positive relationship between beliefs and consumer decision-making process in a private health institution*.

4.2.2 Enabling factors

According to Babitsch, Gohl and Von Lengerke (2012:3), the enabling factors are considered to be those factors that will enable the client to purchase and utilise health care services. In other words, the ability of clients to utilise health care service and access the private health institution will depend on the enabling factors (payment of health care services with personal income, health insurance and family financial support). According to Lo and Fulda (2008:2), the enabling factors are available resources that will enable health care services to be purchased and utilised by the client. Similarly, Sabatino, Thompson, Coughlin and Schappert (2009:58) state that the enabling factors enables access to health institution and allows health care services to be delivered to the client.

4.2.2.1 Personal income

The ability of private health care institution to provide health care services to clients is made possible through their personal income, that is, personal earnings earned through labour or capital and is available for the payment of health care services (Abreu & Greenstein, 2011:301). Access into the private health institution is made possible through the exchange of payment made by the client in the private health institution (Babitsch *et al*., 2012:3). According to Fakuda and Hiyoshi (2012:304), the income of clients has an influence on the decision to utilise health care service. The empirical findings of Fakuda and Hiyoshi's (2012:304) study reveal that clients with lower income had higher rates of morbidity and ill health. In other words, clients with insufficient income are less likely to have access to private health institution and the lack of access for the prevention and treatment of sickness results in the death of the client.

In addition, USAID (2008:16) reports that Nigerian clients with lower income are less likely to utilise the costly health care services provided by the private health institutions. This indicates that the private health institution is utilised by clients that have sufficient income (higher income) to pay for the costly health care services. Muhammed, Umeh, Nasir and Suleiman (2013:64) report that as a result of low personal income, many clients prefer to utilise chemist/pharmacies and very few

utilise public health institutions and the rest utilise traditional medicines and some prefer to utilise the private health institution for treatment.

According to Devaux and De Looper (2012:17), income related inequalities (low or high personal income) influence the utilisation of health care services from a private health institution. This indicates that high personal income can grant a client easy access to purchase and utilise health care services whilst a low personal income is less likely to grant access. Devaux and De Looper (2012:17) affirm that clients in 19 Organisation for Economic Cooperation and Development (OECD) countries with high income are more likely to visit the health institution than the low income clients. Scheppers *et al*. (2006:340) refer to personal income as personal enabling resources. According to Scheppers *et al*. (2006:340-341), high medical cost and the absence of personal income to pay for health care services or poverty can become a barrier which restricts the use of health care services from a private health institution.

Furthermore, Swartz (2009:69) asserts that personal income can create disparities in the access and utilisation of health care services in the private health institution. According to Swartz (2009:69), poor clients (low-class) have more unmet health needs than clients in the middle-class and high-class. This indicates that people with low personal income are at high risk of poor health, a higher prevalence of chronic diseases and restricted access to utilise health care services in the private health institution for wellness. Due to the absence of personal income to pay for health care services in a private health institution Swartz (2009:69) asserts that a country's workforce can have poor health; there will be an increase in causalities and job loss; the country can become poorer and citizens will have a low quality of life; and, as a result, the life expectancy of clients will be reduced. Therefore, the personal income of a client will determine its access and utilisation of health care services in the private health institution.

On the basis of the arguments that income influences utilisation of health care services in the private health institution, it is hypothesised that:

H^4: *There is a positive relationship between personal income and consumer decision-making process in a private health institution*.

4.2.2.2 Health insurance

Health Insurance is an enabling factor that grants access to the utilisation of health care services in the private health institution. In order to avoid payment of health care services with personal income, clients resort to the use of health insurance coverage in accessing the private health institution (Mullner, 2009:324-325). According to Mullner (2009:325), an absence of health insurance coverage and low personal income is highly associated with lower health status and an increased mortality rate. McIntyre (2012:489) suggests that health insurance (universal coverage) protects a client from the financial cost of health care and ensures access and utilisation of health care services by the rich and poor.

Scheppers *et al*. (2006:326) state that the increased cost of health care services can restrict clients from utilising health care services, especially, when they have low income and are not covered by health insurance. Similarly, Mullner (2009:325) affirms that health insurance coverage is a factor that can assist clients on making decisions to access and utilise health care services in the private health institution. Chomi, Mujinja, Enemark, Hansen and Kiwara (2014:2) refer to health insurance as an enabling characteristic that a client has at its disposal, to enable access in the utilisation of health care services in the private health institution.

According to Chomi *et al*. (2014:1), health insurance is an important factor that is used as a health financing reform in the middle and low income countries. This indicates that health care services are provided by means of health insurance coverage to reduce the financial barriers and increase utilisation of health care services by clients. The access to insurance coverage can promote good health and improve the well-being of clients. Furthermore, the availability of health insurance can encourage a client to seek health care services frequently from private health institutions. In addition, the availability of insurance coverage prevents the occurrence of unforeseen sicknesses and protects a client from financial strain that may arise as a result of unexpected medical bills (Chomi *et al*., 2014:1).

In Nigeria, health insurance is offered by private organisations and the government agency (National Health Insurance Scheme). In order to have access to health care

services by means of health insurance coverage, clients are covered by their employer, government or they pay with personal income to be covered by private health insurance. Specifically, the government through NHIS currently covers employees that are employed in the formal employment sector. However, plans are made to extend the insurance coverage to all Nigerians by 2015 (NDHS, 2008:44).

Despite plans to extend coverage to all Nigerians by 2015, Onwujekwe *et al*. (2011:2) assert that only a small percentage of Nigerians that work with the federal government are presently covered. As a result, many Nigerians lack the ability to utilise health care services by means of insurance coverage. According to Normand and Weber (2009:28), a universal insurance coverage in a country can promote health and discourage health disparity amongst the rich and the poor, it can reduce the payment of health care services with personal income, it can improve transparency of prices and costs of health care services, and increase clients' (old and young) decision to utilise and access health care services.

On the basis of these findings, it is hypothesised that:

H^5: *There is a relationship between access to health insurance and consumer decision-making process in a private health institution*.

4.2.2.3 Family financial support

The family is seen as an important social unit in the society and the beliefs and values of a client relating to illness, health and cure are formed from this social unit. This indicates that, a client's value, health belief, health practises, habits, custom and rituals, attitudes to utilisation of health institution, response to illness are learnt from the family unit (Kenner & Lott, 2007:499). Diaz, Stahl, Lovis-McMahon, Kim and Kwan (2013:195) affirm that the family shapes the medical behaviour and attitudes, health care service utilisation, and decisions of clients regarding health institutions. Diaz *et al*. (2013:195) stipulate that the family is a factor that affects utilisation of health care services amongst clients across different social economic backgrounds. In other words, to promote access and to improve the decision to utilise health care

services, the family provides support in three forms, namely, emotional (encouragement), financial (monetary) and informational support (advise).

Furthermore, the Institute of Medicine and Board on Health Care Services (2002:51-54) states that the decision of a client to utilise health care services is influenced by the socio-economic background of the family. In other words, a client that comes from a wealthy family is likely to have greater access to health care services either by means of health insurance coverage or payment made through personal income, whilst a client that comes from a poor family may have restricted access to utilisation of health care services in the private health institution. A client can also have access and utilise health care services by means of insurance coverage provided by the family's employer (Chomi *et al*., 2014:2).

Scheppers *et al*. (2006:326) state that numerous clients attempt to solve their need for wellness on their own but if the cost of health care services is more than their personal income, family members and friends are consulted for financial assistance. Scheppers ***et al'***s. (2006:328) research findings reveal that the family is advantageous in providing financial and emotional support and an absence of this can create a barrier to the decision made in utilising health care services in the private health institution.

Due to the empirical evidence that family financial support given by members of the family to a client can increase access to and utilisation of health care services in the private health institution (Lindley & Mark, 2010:89), it is hypothesised that:

H^6: *There is a relationship between family financial support and consumer decision-making process regarding private health institution*.

4.3 DECISION-MAKING PROCESS AND BUYING PROCESS FOR SERVICES

Clients make daily decisions to make choices regarding the type of health care services and health institution to utilise to satisfy their need for wellness. Human Service (2012:4-23) refers to decision-making as a 'highly personal process' that enables a client to make choices amongst preferable few and further act (purchase)

on the choice selected. However, the decision-making process and buying process for services is a problem solving process that consumer/client will go through to enable them to make purchase decisions on goods and services that will satisfy their needs (Kurtz & Boone, 2010:153).

Furthermore, clients pass through the buying process for services in order to make choices regarding the type of health care services and health institution to utilise (Hoffman & Bateson, 2010:87), whilst consumers pass through the decision-making process in order to make decisions in purchasing tangible goods (Kotler & Keller, 2011:188). The similarity between these two processes is that clients and consumers pass through the decision-making process and buying process for services to make purchase decisions and the difference is that, buying process for services is to make purchase decisions on services, whilst decision-making process is to make purchase decisions on goods (Stafford, Ganesh & Garland, 1996:8). Boshoff and Du Plessis (2009:63) and Govindarajan (2007:97) reveal that consumers and clients will pass through the following similar stages in the decision-making process and buying process for services:

Need recognition: Need recognition is the first stage that consumers and clients pass through in the decision-making process and buying process for services. Consumers recognise a need to purchase goods, whilst clients recognise a need to utilise health care services. Armstrong and Kotler (2005:161) suggest that need recognition can be influenced by consumers' and clients' internal stimuli and external stimuli. This indicates that consumers' and clients' internal stimuli such as hunger thirst and sex influence them to make purchase decisions, whilst external stimuli, such as, advertisement influence consumers and clients by alerting them to their needs and reasons to make a purchase.

Information search: Information search is the second stage of the decision-making process and buying process for services. Consumers and clients engage in information search as a means to resolve their identified needs. In order to make purchase, consumers and clients seek information from internal sources (experiences), group sources (family, friends and colleagues) and marketing sources (advertisements display and packages). Other information sources include, public

sources (media reports and ratings from independent organisations) and experimental sources (consumers and clients gather information by examining and handling products or from the services environment or servicescape) (Furiji *et al*., 2012:80; Ramsaran-Fowdar, 2008:105; Reimer & Kuehn, 2005:786).

Kumar and Raju (2013:37) state that information sources, such as, advertisements can influence the purchase decisions of consumers and clients. In other words, consumers and clients make decisions to purchase goods and services due to the influence of a well displayed advertisement (marketing sources) (Kumar & Raju, 2013:37). Information gathered from family members and friends (group sources) on the basis of their experiences can influence consumers' and clients' decision to purchase goods and services. In other words, family members and friends pass information through word-of-mouth to consumers and clients, stressing the advantage or disadvantage of utilising such goods or services. This creates a situation that influences how consumers and clients decide on purchasing particular goods or services from a private health institution (FreshMinds, 2011:24; Strydom, Da Silva Esclana, Diginis, Du Plessis, Machado, Mpinganjira, McIntee, Rudansky-Kloppers & Theron, 2011:58-60).

FreshMinds (2011:7) suggest that consumers and clients are influenced by social media and organisational ratings (public sources) in that they engage in reading the opinions and reviews concerning the organisations that offer the goods and services they need to purchase. Furthermore, top ratings and positive review and opinions from social media on goods and services can influence consumers and clients to make purchase decisions.

Consumers and clients are also influenced by experimental sources (information gathered by assessing and handling goods or from the services environment). In other words, when clients gather information by assessing and handling goods, they are influenced by product attributes, such as, brand name, price, quality, quantity, colour, attractive packaging, safety, user and environmental friendly and weight (Akpoyomare, Adeosun & Ganiyu, 2012:197). Similarly, when clients intend to purchase services, they gather information by assessing the quality of the interior and exterior of the services environment. Clients are influenced to make purchase

decisions when high quality is perceived from the services environment (Kotler & Keller, 2011:380).

Evaluation of alternatives: The third stage in the decision-making process and buying process for services is the evaluation of alternative goods or services suppliers. Consumers and clients use the information gathered to evaluate the attributes and benefits of possible alternatives in their evoked set. Consumers and clients are influenced by personal evaluation criteria at this stage of evaluation of alternatives (Nutt, 1998:1149). In other words, consumers' and clients' decisive factors can influence them to select one and reject all other alternatives in their evoked set. Consumers for example, may decide to select a Toyota car as a preference from other alternatives on the basis of evaluation criteria such as price, quality, safety, speed and fuel efficiency, whilst a client may decide to make a particular private health institution its purchase preference on the basis of evaluation criteria, such as, specialty in treatment, neatness, quality equipments, professionalism, quick customer services and privacy.

The decision-making process differs from the buying process for services in that consumers go ahead to make purchase decisions and experience the post purchase behaviour, whilst in the buying process for services, clients request services from chosen supplier or initiate self-service, services is delivered, performance of services is evaluated and future intentions are considered (Boshoff & Du Plessis, 2009:63; Govindarajan, 2007:97). The purchase decision and post purchase behaviour stage of the decision-making process is presented.

Purchase decision: Consumers make purchases on goods after evaluating and selecting a preferred one from its evoked set of preferred alternatives. This stage allows consumers to use, feel and experience the goods that they purchased. Furthermore, utilisation of the goods purchased allows consumers judge and confirm if the right purchase decision has been made.

Post purchase behaviour: Post purchase behaviour is the final stage of the decision-making process. During the post-purchase stage of the decision-making process and buying process for services, consumers must have had an actual

experience of the goods purchased. Consumers judge the quality of the goods that have been purchased. The outcome of the evaluation of the goods purchased, results in either satisfaction or cognitive dissonance (Hoffman & Bateson, 2010:92). Boshoff and Du Plessis (2009:63) present the last three stages of the buying process for services in the following way:

Request of services from chosen supplier or initiate self-service and service delivery: These stages are the fourth and fifth stages of the buying process for services. Boshoff and Du Plessis (2009:63) refer to this stage as the service encounter stage. During this stage, the clients interact directly with the services provider when the services are requested, purchased and delivered simultaneously. During this stage, client's experience of services is significant as it will influence future decision-making process. In other words, clients are likely to be influenced to make repeat purchase decisions when they experience quality in areas, such as, atmosphere (lighting, neat environment, smell, good scent, colour, music and temperature), functionality (top-notch equipment, professionalism, quick service, respect, empathy and friendliness), signals (signs, artworks and symbols) and designs (layout of building, well designed entrance and parking space) (Lovelock & Wirtz, 2004:285-293).

Evaluation of service performance and future intentions: The final stage of the buying process for services allows clients to evaluate the performances of the services that are purchased and delivered. Lovelock and Wirtz (2004:37) state that the outcome of this stage will influence the future intentions of clients. This indicates that the satisfaction or cognitive dissonance (outcome) of a client regarding the purchase of services will determine if a client will make a repeat purchase and recommend services to other clients.

Health care providers should understand the importance of the decision-making process/buying process for services in order to craft marketing strategies and effectively market their goods/services to the right clients/customers (Hoffman & Bateson, 2010:82). Furthermore, health care providers have gone beyond understanding the process that clients follow, to understanding what and who influences the decision-maker. In other words, health care providers focus more on

understanding, targeting and appealing to clients in charge of the purchase decision (Stafford *et al*., 1996:18). Health care providers, for example, will focus on targeting and sending the right marketing communication to pregnant women or mothers because they are influential in the decision-making process in the purchase of health care service for a place of delivery.

Furthermore, decision-making or decision-makers can also be influenced by expert advisors. The empirical findings of Meshi, Biele, Korn and Heekeren (2011:1) reveal that expert advise can influence the purchase decision of clients/consumers. In other words, clients that are influential in decision-making are likely to be influenced by other people who are high in authority, have an in-depth knowledge and can proffer quality advise concerning the purchase of certain goods or services. The empirical findings of Meshi *et al*. (2011:10) indicate that clients/customers will accept advise from an expert because they believe that the advise received by them will enable them to make the right purchase decision that will yield valuable outcome.

Furthermore, decision-making can be influenced by the religion and spirituality of a client. In other words, religion can influence how client/consumers utilise certain services or purchase certain products (Padela, 2011:12). The empirical findings of Padela (2011:12) reveal that as a result of religion, consumers can be prohibited from making purchase decisions on certain drugs such as, contraceptive. Furthermore, the empirical findings in the decision to utilise health care services show that, clients will believe that God is or other spiritual beings are in control of their health and the cause of their illnesses. Thus, they will seek well-being by performing religious practises in order to heal themselves.

According to Roberto, Weeks and Matheis-Kraft (2001:81), one of the reasons why clients/consumers will make a decision to repeat purchase is their past experience of the quality of goods or services purchased. The empirical findings of Roberto *et al*. (2001:81-82) reveal that older adults will make a decision to consent to a different approach of treatment as a result of their personal past experiences or the past experiences of family members and friends. Similarly, the empirical findings of Pickett-Baker and Ozaki (2008:282-290) affirm that decision-making is not only

influenced by clients' past experience of a product or services, but also by well known brands, advertisement, word-of-mouth, price and loyalty.

Decision-making can also occur in the health institutions in the area of information and treatment options (Young, Rogers, Dent & Addington-Hall, 2009:2162). This indicates that medical practitioners provide medical information to clients about diagnosis, the nature of their sickness and options on their preference in the treatment of their sickness. In other words, clients become active partners of the medical practitioners in exploring treatment options and making decisions on the appropriate treatment for their illness (Coutler, Parsons & Askham, 2008:6). Coutler *et al*. (2008:6) suggest that clients' involvement in the decision-making concerning their treatment options helps them to feel relaxed and in control of their health situation.

4.4 THE MODELLED OUTCOMES OF DECISION-MAKING PROCESS

The modelled outcomes of the decision-making process in this study refer to the post purchase buying behaviour (customer satisfaction and cognitive dissonance). The outcomes refer to the actions or behaviour of a client after the purchase of health care services from a private health institution (Joubert, 2010:139). Clients/consumers become satisfied if the services or goods purchased exceed their expectations, but they experience cognitive dissonance if the services or goods purchased are less than what they expect (Joubert, 2010:139).

4.4.1 Customer satisfaction

Customer satisfaction refers to the contentment that a client has regarding prior purchase of health care services from a private health institution. Customer satisfaction has been regarded as an important factor in marketing, in that, it makes the satisfied client become brand ambassador that helps to spread good word-of-mouth about the quality of a service and the outcome of this leads to business success, profitability or superior economic returns (Anderson, Fornell & Lehmann, 1994:63; Ha, 2006:138). According to Ha (2006:137), customer satisfaction is a key

determinant that influences a client's decision to continue or discontinue utilisation of health care services from a selected health institution.

Kardes, Cronley and Cline (2010:209) suggest that customer satisfaction has an influence on decision-making process (future purchase). In other words, if customers are satisfied with the services purchased they are likely to consider purchasing in the future. Similarly, Mosahab, Mahamad and Ramayah (2010:73) assert that if clients are satisfied they will make a decision to purchase again. Furthermore, Jost (2007:93) reveals that purchase decisions made in health care settings are usually complicated because of the level of uncertainty in the quality of health care services and as a result clients make purchase decisions on the basis of predictions. Due to the level of uncertainty of the quality of health care services that is to be purchased, clients perform an intensive search to ensure that they make the right purchase decision.

Empirical findings reveal that the satisfaction of one client regarding the utilisation of a health institution can help reduce the level of uncertainty and shorten the decision-making process of another client. In other words, a client that seeks a health institution for a chronic medical need can seek advise and information from a family or friend (Taghizadeh, Taghipourian & Khazaei, 2013:2570). The empirical findings of Taghizadeh *et al*. (2013:2570) indicate that if a client's family, friend or acquaintance is satisfied with the performance and quality of services of the private health institution, the client passes on the information. This information can help reduce the level of uncertainty in quality and shorten the rigorous decision-making process of a client that has a purchase intention. Thus, the satisfaction of a client increases positive word-of-mouth, reduces the uncertainty of quality that is unknown to the new client, shortens an extensive decision-making process, encourages repurchase and brand loyalty.

Furthermore, Deng, Lu, Wei and Zhang (2010:290) reveal that satisfied clients are likely to be loyal, committed and consider a repurchase intention. The empirical findings of Deng *et al*. (2010:296) indicate that satisfaction influences loyalty. This indicates that they will prefer and continuously purchase the services because of the satisfaction derived from earlier purchase. The loyalty of clients as a result of their

satisfaction, has an impact on the growth and profitability of the business. According to Flint, Blocker and Boutin (2011:222), organisational relationships have an influence on customer satisfaction. In other words, an organisation that maintains good rapport with clients, adapts to clients' changing needs, creates what the clients value and improves their services delivery to keep customers satisfied.

The empirical findings of Williams and Naumann (2011:26) reveal that there is a strong positive relationship between the financial performance of a business and customer satisfaction. This indicates that when customers are satisfied they are likely to be loyal and have a willingness to recommend the services to other clients. Williams and Naumann (2011:26) assert that this situation (satisfaction, loyalty and willingness to recommend) can impact on the revenue, sales and thus boost the financial performance of the business.

Percy and Rosenbaum-Elliot (2012:104) indicate that there is a relationship between the client's decision-making process and customer satisfaction. According to Percy and Rosenbaum-Elliot (2012:104), satisfied clients will become loyal to a health institution and are unlikely to switch. Clients will repeat purchase because of the satisfaction and assurance of quality derived from earlier purchase and they will ignore the time and cost of searching for a new private health institution when there is a need to repeat purchase. Thus, specific stages (pre-purchase stage) in the decision-making process that is needed to be followed in order to make a new or repeated purchase regarding the selection of a private health institution will be ignored. In other words, clients will go ahead to make a direct purchase because of the satisfaction that has been experienced from an earlier purchase.

On the basis of the empirical findings, it is hypothesised that:

H^7: *There is a relationship between the consumer decision-making process and customer satisfaction in a private health institution*.

4.4.2 Cognitive dissonance

Cognitive dissonance is referred to as a post-buying conflict that occurs after the purchase of health care service. Post-buying conflict occurs when a client experience regrets, anxiety or doubts if the correct decision has been made regarding the purchase of a health care services or utilisation of a health institution. Clients feel a sense of regret especially when the purchase is a high involvement purchase or when a complex or intensive decision-making process has been followed (Joubert, 2010:140). Hoffman and Bateson (2010:92) refer to cognitive dissonance as doubt in the consumer's mind regarding the health care services that is purchased and health institution that has been utilised.

According to Kardes *et al*. (2010:209), cognitive dissonance involves "behaviour-attitude inconsistency" and it occurs after the decision-making process. In other words, clients compare its expectations (exceed or did not exceed expectation) or has contradicting thoughts about the purchase. Batra and Kazmi (2009:462) state that the cognitive dissonance is related to the clients' decision-making process, in that, the cognitive dissonance occurs between the client's prior evaluation and the purchase decision.

Furthermore, Haksever and Render (2013:47) assert that the client decision-making process is incomplete without the clients' final outcome (satisfaction or cognitive dissonance) of the services purchased in the decision-making process. This indicates that after the purchase of the health care services from the selected health institution, one of the following outcomes (a feeling of satisfaction that services received exceeds expectation or the performance of service received is below expectation) should occur. Clients' outcomes that result in a negative disconfirmation is most likely to affect the decision-making process of a repeat purchase. A client, for example, that experiences a bad surgical operation from a health institution is likely not to repeat purchase from that health institution and if there is going to be a repeat purchase, the client is likely to perform a more intense search, making the new decision-making process lengthy and time consuming (Haksever & Render, 2013:47).

Joubert (2010:141) asserts that cognitive dissonance is a learning process, a final stage and not the end of the client's decision-making process. This indicates that, experiences and information gained as a result of past purchase is stored in the memory of the clients and it is used as criteria for measuring quality when the client starts a new decision-making process for another purchase of health care services in a private health institution.

On the basis of the findings that the consumer decision-making process has a relationship with cognitive dissonance, it is hypothesised that:

H^8: *There is a relationship between the consumer decision-making process and cognitive dissonance in a private health institution*.

4.5 SUMMARY

This chapter discussed the predisposing and enabling factors and their influence on the decision-making process. The variables and attributes of the influencing factors on decision-making process were highlighted and discussed comprehensively. Furthermore, discussion on decision-making process and buying process for services and the modelled outcomes (customer satisfaction and cognitive dissonance) of the decision-making process were also presented for reasons of clarity. The following chapter will provide discussion on the research design, methodology, sampling process, data collection method and statistical method that will be used for this research study.

CHAPTER 5
RESEARCH DESIGN AND METHODOLOGY

5.1 INTRODUCTION

The previous chapters provided detailed discussion of the clients' decision-making process, an overview of the Nigerian health care sector and the theoretical model that is developed on the basis of the literature reviewed. The aim of this chapter is to provide essential information regarding the research design and methodology that will be used for this research study. The research design, paradigm and methodology including a detailed description of the sample and sampling process, as well as the structure and of the research instrument will be provided. Data collection methods and the statistical methods used in analysing the data in this study will be discussed extensively for clarity purpose.

5.2 RESEARCH DESIGN

The research design is crucial in a research study, because it forms the basis on which the research study is carried out. In other words, it is a strategy or a structure that helps to align several parts of the research study in a logical and coherent way thereby addressing the research problem effectively (Kirshenblatt-Gimblett, 2006:9). Kirshenblatt-Gimblett (2006:9) states that the work plan of the research study flows on the basis of the research design that is selected and it ensures that the evidence obtained enables the researcher to provide answers to the initial research questions as clearly as possible. According to Hair *et al*. (2003:40), the research design represents the master plan of the methods and procedures employed by the decision-maker in gathering and analysing data that is needed to resolve the identified research problem. Knight (2010:98) supports this notion by stating that the research design represents the back bone and architecture of an excellent research study.

The research design provides the researcher with a sense of direction on what, whom and how the secondary and primary data will be collected. The research design helps to define the statistical analysis of the primary data gathered and

guides the interpretation of the results (Knight, 2010:98). Furthermore, McDaniel and Gates (2006:33) state that the research design is a framework that addresses the research objectives, hypothesis and ensures that a structure is developed to provide specific answers to the research problem. McDaniel, Lanham and Anderson (2009:4) affirm that research is a process and as such the research design should provide the researcher with an order or act as directional guide for action that will assist the researcher to focus on the research activity throughout the study.

Furthermore, Zikmund and Babin (2010:65) state that there is no single best research design that can be employed in a research study, but the most crucial concern is that the research design selected by the researcher must be able to accomplish the stated research objectives. In the support of the statement above, McDaniel and Gates (2006:33) add that all research designs offer an array of choices that are based on time constraint, research cost and the quality of decision-making information. McDaniel and Gates (2006:33) also report that all research designs have advantages and disadvantages and that the higher the cost that is put into a research study, the more precise and error free information will be obtained.

According to Jalil (2013:8), a research design defines the type of study that is undertaken by the researcher. The types of research design used by numerous researchers are classified on the basis of the type of research questions addressed (exploratory, descriptive) or the data collection tools (survey, quantitative and qualitative). Furthermore, research designs are classified as experimental, non experimental and quasi-experimental design. However, McDaniel and Gates (2006:33-35) classify research designs as descriptive and causal research designs. The choice of the research design (descriptive or causal) is based on the research objectives which is the first step a researcher should take in a research study.

Creswell (2009:3) classifies three types of research designs as qualitative, quantitative and mixed methods in contrast to McGivern (2009:81) who argues that there are four types of research design, namely, cross-sectional research, longitudinal research, experimental research and case study research designs.

5.3 PARADIGM OF THE RESEARCH STUDY

Prior to the collection of secondary and primary data, it is significant that the researcher makes a decision on the research paradigm that is to be employed for the study. The set of beliefs and perception that shape the manner in which an individual views the world is referred to as a paradigm. Paradigm influences researcher's ability to think and it tells the researcher what is logical or not (Robbins, 2009:18). According to Robbins (2009:18), different types of paradigms exist in different subjects of research, all of which are trying to describe, explore or explain relationships. According to Hancock (2007:64), a paradigm refers to a broad framework that comprises perception, a set of beliefs and understanding of several theories and practises that are used to conduct an empirical investigation. Similarly, Joubish, Khurram and Ahmed (2011:2083) suggest that a paradigm is a worldview, framework of beliefs and methods within which a research takes place.

Furthermore, Powell (1997:245) defines paradigm as a structure of critical assumptions with which logical views are evaluated and relationships are established and clarified. Terre Blanche, Durrheim and Painter (2006:6) suggest that paradigms are a comprehensive pattern of thoughts that define the systems of interrelated practise in a scientific discipline. In addition, Gliner, Morgan and Leech (2009:7) highlight the suggestion that a paradigm is not a methodology but more of a philosophy that guides a researcher on how to think and conduct a research. Kinash (2006:6) defines paradigms as sets beliefs and perceptions that motivate the approach of a researcher, whilst the research methods are the techniques that are used to conduct the research.

Della Porta and Keating (2008:25) define the methods of research as the techniques and instruments that are employed in acquiring knowledge. There are three types of research method, namely, the qualitative research method, the quantitative research method and the mixed methods research (qualitative and qualitative) (Johnson & Onwuegbuzie, 2004:14). These three types of research methods will be discussed in order to clarify them.

5.3.1 Qualitative research method

The qualitative research method is a method of research in which numbers or counts are not related or assigned to observations. Rather it is a method that provides description of data that are related to the written or spoken words of participants, their experiences, opinions and perceptions of the world (Brynard & Hanekom, 2006:37). According to Brynard and Hanekom (2006:37), the crucial aspect of the qualitative method is that it focuses on providing data which is based on the participant's point of view and forces the researcher to focus more on understanding rather than explaining. In other words, the qualitative research method forces the researcher to have a personal relationship with the participant so as to have an in-depth understanding of the participant's point of view or their real life experiences.

This approach of having an in-depth understanding and gaining insight into participant's views enables the researcher to collect accurate and rich data. It also allows the researcher to transcribe the exact actions, written and spoken words of the participant (Brynard & Hanekom, 2006:37). According to Della Porta and Keating (2008:26), the qualitative research method is an 'interpretive research method' that is aimed at understanding events in such a way that data is gathered by discovering meaning from participants and the external world. Della Porta and Keating (2008:28) further report that the qualitative research method uses an approach that is interpretive, observatory and naturalistic.

Zikmund and Babin (2010:131) define qualitative research as a method that allows the researcher to interpret, understand and address marketing objectives without the use of numerals. In other words, qualitative research focuses more on quality than in quantity and it does not employ the use of statistical procedures or numbers to measure variables rather, words or orals and pictures are used to interpret data. Furthermore, Denzin and Lincoln (2011:3) reveal that qualitative research is an activity that is undertaken by the researcher to locate the observer of the world and it employs the use of interpretive and material practises that makes the world visible. Qualitative research employs the use of interpretive and naturalistic approach to study things in their natural form thereby allowing the researcher to give meaning or interpret the meaning that participants have given to it (Denzin & Lincoln, 2011:3).

Furthermore, the researchers employ empirical materials such as field notes, interviews, conversation, personal experience, real life story, photographs, historical, observational, interactional and visual texts, recordings, and memos to perform their research activity (Denzin & Lincoln, 2011:3). Cant *et al*. (2005:8) confirm this finding by stating that the qualitative research method focuses on the use of exploratory research design and materials. This indicates that the researcher explores a situation or topic by using empirical materials or techniques (in-depth interviews and observations) to gather data from participants (McGivern, 2009:47).

Zikmund and Babin (2010:135) report that the data or findings in a qualitative research are expressed in words, pictures or oral but rarely as numbers. Furthermore, Zikmund (2003:110) states that qualitative research tends to center on the collection of detailed amounts of primary data from relatively small samples of subjects by asking questions or observing behaviour. The data collected by the researchers are analysed by identifying and coding themes and categories leading to findings that answer the research question, thus adding to theoretical knowledge and practical use (Boeije, 2010:11).

However, qualitative research method lacks the critical element of true reliability because the analysis of data is constrained to the use of very subjective content, interpretive or semiotic analysis procedures (Hair *et al*., 2003:213). The qualitative research method thus, makes it difficult for hypotheses and theories to be tested with large participants. Data collection is limited to smaller sample sizes that do not necessarily represent the population of researchers' interest and data analysis is time consuming. Researchers may also become easily biased and results from the qualitative analysis are easily altered by the researcher (McDaniel & Gates, 2006:80; Zikmund & Babin, 2010:134).

Despite its disadvantages, the qualitative research method can be functional in understanding and making discovery in the market place as well as observing consumer behaviour and decision-making process (Hair *et al*., 2003:213). According to McGivern (2009:46-47), the qualitative research method is advantageous because it provides the following:

- rich, highly valid and detailed descriptions of data;
- deep feelings and emotional response from participants;
- data collection based on a naturalistic approach; and
- low cost of carrying out the research.

Due to the advantage of generating valid data, the qualitative research method was employed in this study to pre-test (pilot study) the measuring instrument. According to McDaniel and Gates (2006:279), a research study should not be carried out without pre-testing the measuring instrument. Thus, the measuring instrument was tested on a smaller sample size to ensure accuracy and correct common mistakes, such as, poor coding and the misinterpretation of questions by respondents. This approach enabled the effectiveness of the measuring instrument when it was deployed on the large sample size of the study (McDaniel & Gates, 2006:279).

5.3.2 Quantitative research method

The quantitative research method refers to the method in which scientific or statistical analysis of data is applied in a research study (Bradley, 2007:278). In other words, this method of research deals with numbers and statistics. According to Somekh and Lewin (2011:220), the quantitative research method uses statistical tools and techniques to describe and interpret data that can be quantified and measured numerically. According to McGivern (2009:46), the quantitative research method is useful in describing the characteristics of a population and in quantifying, validating and testing hypotheses and theories. Creswell (2009:4) supports this notion by stating that the quantitative research method is to test hypotheses, theories, and questions as well as to analyse statistically the data collected from a large sample size.

Additionally, Creswell (2009:4) reports that the quantitative research method focuses on two strategies of inquiry, namely, surveys and experiments. Survey inquiry in quantitative research study requires that the researcher should study a sample size of a population and provide a numeric description of the trends, attitudes and opinions of the sample size of the researcher's interest. The experimental inquiry

(true experiments or quasi-experiments) in a quantitative research method requires the researcher to use a specific treatment on two different groups and further determine if the treatment influences the group experimented on and the outcome or score of the groups (Creswell, 2009:12).

Further the quantitative research method focuses on the use of descriptive and causal designs. This indicates that structured and standardised questionnaires, surveys and experiments are used to collect primary data from a large sample size that represents the target population. The data collected from respondents in a quantitative research study is measured, tested and validated and the findings are expressed in numbers, percentages and mean (McGivern, 2009:47).

The quantitative research method was employed for the purpose of this research study. According to Hair *et al*. (2003:255), the quantitative research method is the core method that is used in a marketing research. Hair *et al*. (2003:255) reveal that in quantitative research method, researchers make use of descriptive research designs that allow them to collect raw data from a large sample size, analyse the raw data gathered by means of advanced statistical techniques and provide precision in the relationships that exist between the independent and dependent variables. This research study used the quantitative research method as described by Johnson and Onwuegbuzie (2004:19), because it found the description valuable for the following reasons:

- it was useful and quick for gathering the primary data;
- its constructed hypothesis was tested and validated;
- numerical or quantitative data were precise;
- the use of a statistical software made the analysis of data less time consuming;
- it was helpful when used to understand the behaviour or characteristics of the population; and
- results were relatively independent of the researcher and it was not deficient in the reliability and validity of data.

The secondary and primary research was conducted to achieve the aim of this quantitative research study. The secondary research involved the gathering of information from research or studies that were performed previously (Gratton & Jones, 2010:8). According to Bradley, Kelley and Hudson (2010:29), secondary research involves gathering and analysing existing research. Bradley *et al*. (2010:29) state that in a secondary research, numerous sources are consulted and summarised to provide a basis for arguments in a study. This approach of conducting and gathering existing information was cost effective and fast (Hulley, Cummings, Browner, Grady & Newman, 2007:207). Furthermore, the secondary research was carried out by consulting credible websites, books, journal articles and newspaper through the Nelson Mandela Metropolitan University's library.

Primary research refers to the research that involves the collection of first hand data. This method employs the use of a measuring instrument to collect new and original data from a sample size of the study (Gratton & Jones, 2010:8). Driscoll (2011:154) postulates that the primary research involves the use of a scientific method in gathering first hand data that will contribute to existing knowledge. According to Rugg and Petre (2006:32), primary research is essential in academia, because it advances knowledge and provides answers to research questions.

Denscombe (2003:236) attests that the results of a primary research are presented in numbers, graphs and tables and these findings portray a sense of credibility and objectivity. The primary research in this study was conducted by gathering first hand data using a measuring instrument (questionnaire). The primary data gathered was analysed to provide answers to the research questions which were formulated for this study.

Table 5.1, as presented by McGivern (2009:46), shows the differences of the qualitative and quantitative research methods in the type and nature of questions and response, sample size, sampling approach, collection of primary data and the cost associated with the research method.

Table 5.1: Differences between qualitative and quantitative research methods

Topic	Qualitative research	Quantitative research
Research enquiry	Exploratory, descriptive and explanatory	Exploratory, descriptive and explanatory
Nature of questions and response	What, when, where, why, below the surface and emotional responses. Exploration, understanding, and idea generation	Who, what, when, where, why, how many relatively superficial and rational responses. Measurement, testing and validation
Sampling approach	Non-probability methods (purposive)	Probability and non-probability methods
Sample size	Relatively small	Relatively large
Data collection	Flexible, interviews and observations, less standardised, less structured, more open-ended and non-directive questions	Not very flexible, interviews and observation, standardised , structured, more closed questions
Data	Words, pictures, diagrams, detailed and in-depth idiographic description, context rich, high validity, low reliability, statistical inference not possible	Numbers, percentages, means, less detailed or depth, nomothetic description, context poor, high reliability, low validity, statistical inference possible
Cost	Relatively high cost per respondent, relatively low project cost	Relatively low cost per respondent, relatively high project cost

Source: McGivern, 2009:46.

5.3.3 Mixed methods research

The mixed methods research is a method of research that is gaining grounds in the field of marketing. It is the use of both the qualitative and quantitative research methods in conducting marketing research (McDaniel & Gates, 2006:79). Venkatesh, Brown and Bala (2013:2) refer to the mixed methods research as the "third triangulation movement (paradigm)". The mixed method research focuses on the use of multiple research methods in a research inquiry to understand a researcher's interest. Venkatesh *et al*. (2013:3) suggest that in order to use the mixed methods research, the researcher should focus on the research questions, purpose and context of the research study.

According to Zikmund and Babin (2010:132), the mixed method research aims to balance the argument that relates to the superiority on the use of qualitative or quantitative research method when conducting a research study. Zikmund and Babin (2010:132) reveal that numerous researchers combine the qualitative and quantitative research methods to produce an excellent research study. Johnson and Onwuegbuzie (2004:14) support this notion by stating that the mixed method research does not replace the qualitative or quantitative research method, instead, it draws from the strength of both methods and reduces the weakness of the qualitative and quantitative research method in a single research study.

Johnson and Onwuegbuzie (2004:14) also report that the mixed methods research is expansive, as it focuses on the use of multiple approaches in attempting research questions and objectives. This indicates that the mixed methods research will provide detailed answers to the research questions in a quantitative and qualitative method (words, pictures, numbers and narration) to complex research questions. Furthermore, Creswell (2009:4) defines the mixed methods research as an approach to research where the researcher gathers data using the qualitative and quantitative means to understand research problems. In other words, the researcher employs a pluralistic (mixed or diverse) approach in collecting data. This indicates that numerical data (quantitative) and interviews or observations (qualitative) are gathered in order to understand a research problem. The data analysis reported is then a representation of the qualitative and quantitative research method.

Creswell (2003:21) suggests that in conducting a mixed methods research, the first phase should be the quantitative research method (conduct a broad survey to generalise results to a population) and the second phase should be the qualitative research method (the researcher collects data from respondents using open-ended interviews). Furthermore, Johnson and Onwuegbuzie (2004:18) advise that prior to conducting the mixed methods research, researchers should understand the basic fundamentals of the qualitative and quantitative method research. In other words, the researcher should consider and understand the basic characteristics of conducting a quantitative research study (deduction, theory or hypothesis testing, statistical analysis, standardised data collection from large samples, prediction and explanation) and a qualitative research study (induction, theory or hypotheses

generation, discovery, observation, exploration and data collection from smaller sample size).

A stronger evidence for conclusion is provided when the mixed methods research is used. Despite the advantage of the mixed methods research, there is difficulty in mixing both methods properly. It is expensive and time consuming as it requires a deep understanding of using both approaches to conduct a study (Johnson & Onwuegbuzie, 2004:21).

Table 5.2 provides a clear distinction of the qualitative, quantitative and mixed methods approaches as provided by Creswell (2009:17). Table 5.3 explains the philosophical assumptions, strategies, methods and practises of the three types of research approach. The quantitative research approach was used to conduct this research study.

Table 5.2: Qualitative, quantitative and mixed methods approaches

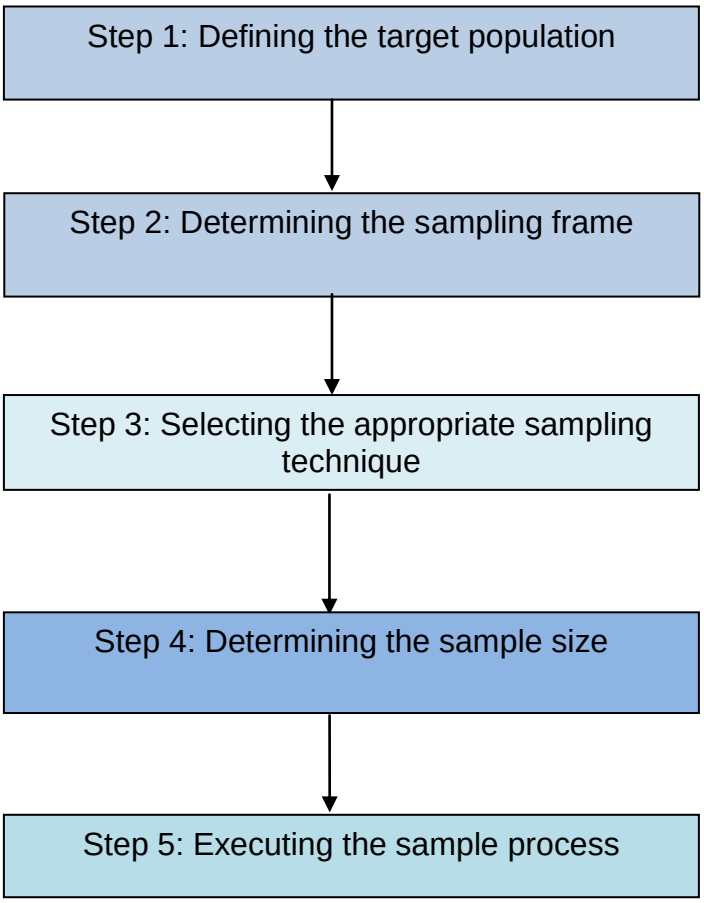
Tend to or typically	Qualitative approaches	Quantitative approaches	Mixed methods
Use these philosophical assumptions	Constructivist/ Advocacy/Participatory knowledge claims	Post positivist knowledge claims	Pragmatic knowledge claims
Employ these strategies of inquiry	Phenomenology, grounded theory, ethnography, case study and narrative	Survey and experiments	Sequential, concurrent and transformative
Employ these methods	Open-ended questions, emerging approaches, text or image data	Closed-ended questions, predetermined approaches, numeric data	Both open and closed-ended questions, both emerging and predetermined approaches, and both quantitative and qualitative data and analysis
Use these practises of research, as the researcher	Positions himself or herself, collects participant meanings, focuses on a single concept or phenomenon, brings personal values into the study, studies the context or setting of participants, validates the accuracy of findings, makes interpretations of the data, creates an agenda for change or reform, collaborates with the participants	Tests or verifies theories or explanations, identifies variables to study, relates variables in questions or hypotheses, uses standards of validity and reliability, observes and measures information numerically, uses unbiased approaches, employs statistical procedures	Collects both quantitative and qualitative data, develops a rationale for mixing, integrates the data at different stages of enquiry, presents visual pictures of the procedures in the study, employs the practises of both qualitative and quantitative research

Source: Creswell, 2009:17.

5.4 SAMPLING

The process of sampling is a technique that involves the collection of data from a fewer group which is selected from a larger group of the sampling population (Kumar, 2014:229). Sampling is a process in which a sufficient number of the right element to be studied is drawn from the population (Sekaran & Bougie, 2010:266). Sampling is essential because it saves time, financial resources and, through it, accurate results are provided (Bajpai, 2011:95). The sampling design process or the series of stages that researchers need to follow in order for the sample size to be determined or selected according to Bajpai (2011:95) are depicted in Figure 5.1.

Figure 5.1: Steps in sampling design process



Source: Adapted from Bajpai, 2011:95.

5.4.1 Defining the target population

Prior to gathering the primary data in a research study, the population and sample frame have to be carefully defined to ensure that the most appropriate source of primary data is gathered and the proper sources from which the data is gathered is correctly identified (Zikmund, Babin, Carr & Griffin, 2012:387). Bajpai (2011:96) explains that when the target population is not properly defined, there is a possibility that the researcher will generate misleading results. The cases that provide the primary data which is used for the study make up the sample frame, whilst the cases that want to be generalized by the researcher make up the population (Montello & Sutton, 2006:144). Lehmann *et al*. (1998:284) refer to the target population as that part of the total population in which the researcher directs the research study to. According to Dahlberg and McCaig (2010:173), the population in a study refers to the group of people or organisations that the researcher is interested in making findings on.

According to Sekaran and Bougie (2010:267), it is important for researchers to define the target population in terms of elements, geographical boundaries and time. This indicates that the researcher should define the population on the basis of the unit of analysis, group of people that the research is directed to within a community and the period of time the data would be collected. Similarly, Dahlberg and McCaig (2010:173) suggest that researchers should consider the research question and the following factors in defining a population:

- **Geographic factors**: Defining a population on the basis of a research conclusion that applies only to the population of a particular town or community.
- **Demographic factors**: Defining a population on the basis of the conclusion that applies to people with a specific level of income, gender, age or religious beliefs.
- **Usage factors**: Defining a population on the basis of the conclusion that applies to people using a particular service.

- **Awareness factors**: Defining a population on the basis of the conclusion that applies to the awareness of a service of the researchers' interest.

5.4.2 Defining the sampling frame

The sampling frame refers to the list of all the elements in the population from which the sample is drawn. Zikmund *et al*. (2012:388) define the sampling frame as the "working population" because the sample frame is responsible for providing the list of all the elements from which the sample will be drawn. Furthermore, Bajpai (2011:96) suggests that researchers should note that sampling is carried out on the sampling frame and not on the target population. Leary (2010:163) asserts that the sampling frame is an essential part of the sampling process, because it provides the list of all the members of the population from which the sample of the researcher's interest is drawn. In other words, it is difficult or impossible to have the current or the old information of the name, home address, email address and phone numbers from an entire population, but the sampling frame makes it possible to have a list or database that has accurate information for a specific part of the population.

Leary (2010:163) as well as Sekaran and Bougie (2010:267) suggest that defining the target population is not enough, because it does not guarantee the access of data collection from every element within it. However, the sampling frame can grant access to information or a listing of each element drawn from the population. In contrast, Hair, Celsi, Money, Samouel and Page (2011:167) argue that the sampling frame may be flawed in that it may not be up-to date, it may or may not include elements that belong to the target population and it is possible that the list may include duplicate information of respondents. Due to these reasons, Hair *et al*. (2011:167) suggest that researchers should confirm the accuracy of the sampling frame list irrespective of where it was drawn originally.

5.4.3 Selecting the appropriate sampling technique

The selection of the appropriate sampling technique is an essential step in the sampling process. The researcher decides what type of technique will be used to determine the sample size at this step. Hair *et al*. (2011:167) postulate that selecting

the sampling technique in a study depends on the objectives of the study, time constraints and the financial resources available to the researcher to conduct the study.

Furthermore, Somekh and Lewin (2011:222) reveal that probability and non-probability sampling are the two types of sampling strategies or techniques that can be used to select the sample from the sample frame. Table 5.3 summarises the sampling procedures that are used in selecting a sample size as discussed by O'Dwyer and Bernauer (2014:78).

Table 5.3: Summary of sampling procedures

Probability sampling procedures	Non-probability sampling procedures
Simple random sampling	Convenience sampling
Stratified random sampling	Purposive sampling
Cluster random sampling	Quota sampling
Systematic sampling	Snowball sampling

Source: O'Dwyer and Bernauer, 2014:78.

The technique by which the members of the population of researcher's interest have a known probability of being selected as part of the sample, is known as the probability sampling technique, whilst non-probability sampling technique is utilised by the researcher when the members of the population do not have an equal chance of being selected as part of the sample (Jackson, 2011:100-101). Similarly, McDaniel and Gates (2006:302) postulate that the probability sampling technique refers to the technique in which the researcher selects respondents in such a way that every element of the population has a known, non-zero likelihood of selection, whilst in the non-probability technique the researcher selects specific elements from the population in a non-random manner.

The **non-probability sampling technique** was used in this study to identify the respondents for this research study. The non-probability sampling technique was chosen because it enabled the sample determined to represent the population when selected accurately. It was cost-effective as the data was gathered speedily at a low

cost per respondent (McDaniel & Gates, 2006:302). Babbie (2012:199) suggests that there are several types of non-probability sampling, such as, convenience, snowball, judgment and quota sampling. Convenience and snowball sampling was used in this research study to identify the respondents.

Convenience sampling is a non-probability sampling technique that involves getting respondents wherever they can be found and whenever it is convenient for the researcher (Jackson, 2011:102). Similarly O'Dwyer and Bernauer (2014:78) affirm that a situation in which respondents are conveniently available for researchers is known as convenience sampling. The use of convenience sampling was helpful in this study because it enabled the researcher to identify the sample conveniently, while being cost-effective and time-effective and efficient (Wilson, 2010:200).

Snowball sampling is a non-probability sampling technique that allows researchers to select respondents on the basis of referrals from other respondents (Babbie, 2012:201). Similarly, snowball sampling is a non-probability sampling technique in which respondents assist the researcher in identifying other respondents that share similar demographic and psychographic characteristics with them (Rios & Rerez del Campo, 2013:199). According to Babbie (2012:200-201) and Rios and Rerez del Campo (2013:199), the use of snowball sampling in this study was advantageous, because it was less expensive. It revealed important insights into the population that was studied and it increased the chance of finding the desired respondents of researcher's interest.

5.4.4 Determining the sample size

Due to the constraint that is associated with time, cost and accessibility in collecting primary data from an entire population, Somekh and Lewin (2011:222) suggest that researchers should select a representative sample size of the population to be studied. The sample is that part of the population that shares or exhibits the same characteristics with the population. According to Kumar (2014:230), a sample is a sub-group of the entire population of researcher's interest. Somekh and Lewin (2011:222) caution that researchers should select the sample size accurately in such

a way that it represents the population so that the results can be generalised on the population.

Nayak (2010:469) postulates that it is essential for researchers to have a satisfactory sample size that is sufficient and representative of the target population. Failure to have a sample size that is a representative of the population may provide results and conclusions that are not accurate. Murthy and Bhojanna (2008:158) support this notion by stating that if the elements of researcher's interest within the sample are great or the researcher desires a higher level of confidence in the estimate and precision in data or the researcher wants to reduce non-response error (low response rate associated with respondents refusal to complete questionnaire), then a larger sample size will be needed.

Prior studies reveal that determining the sample size is complex and is dependent on and constrained by factors such as time, resources, availability of respondents, completion rate of respondents, shape and form of the data to be collected, objectives of the research and analysis (Bajpai 2011:97; Hair *et al*., 2011:176: Leary, 2010:163). Leary (2010:164) and Zikmund *et al*. (2012:403) suggest that in order to overcome the difficulties associated with determining a larger sample size that is a representative of the population, researchers should prepare the budget and plan ahead of time or utilise a sampling technique that is simple and less time consuming.

5.4.5 Executing the sampling process

The process of executing the sampling process is the final step in the sampling process. The researcher provides detailed specification and information regarding each step in the sampling process (population, sampling frame. sampling technique and sample size) and executes them effectively (Rios & Rerez del Campo, 2013:196).

The population of this research study consisted of clients that utilise the private health institutions in Lagos state, Nigeria. The sampling frame of researchers' interest was drawn from Lagos state using the non-probability sampling technique (convenience and snowball sampling). The sample size determined was 450

respondents utilising private health institutions in Lagos state, Nigeria. However, in order to achieve the stipulated data collection time, avoid late completion rate and disappointment from respondents, a total of 500 questionnaires were distributed to achieve the targeted sample size of 450. Table 5.4 summarises the demographic profile of the 450 respondents that was drawn from the Lagos state, Nigeria.

Table 5.4: Demographic profile of respondents

Demographics	Range	N	%
Gender	Male	243	54
	Female	207	46
	Total	**450**	**100**
Age	0-29	152	34
	30-39	171	38
	40-49	85	19
	50-59	28	6
	60 and above	14	3
	Total	**450**	**100**
Monthly Income	₦1,000 - ₦20,000	55	12
	₦21,001 - ₦40,000	84	19
	₦41,001 - ₦60,000	87	19
	₦ 61,001 - ₦80,000	63	14
	₦81,001 - ₦100,000	50	11
	₦101,001 - ₦120,000	38	9
	₦120,001 and above	73	16
	Total	**450**	**100**
Marital status	Single	204	46
	Married	222	49
	Divorced	15	3
	Widowed	6	1
	Co-habitant	3	1
	Total	**450**	**100**
Family size	1	59	13
	2-4	201	44
	5-7	147	33
	8-10	30	7
	11 and above	13	3
	Total	**450**	**100**

Table 5.4: Demographic profile of respondents (cont.)

Demographics	Range	N	%
Level of Education	No formal education	1	0
	Primary school	2	0
	Junior secondary	2	0
	Secondary school	34	8
	Diploma	75	17
	Undergraduate degree	153	34
	Post-graduate degree	166	37
	Others please specify	17	4
	Total	**450**	**100**
Nature of Field	Manufacturing	42	9
	Retailing	47	10
	Wholesaling	48	11
	Services	224	50
	Other	89	20
	Total	**450**	**100**
Occupation	General worker	93	21
	Supervisor	40	9
	Foreman	10	2
	Admin C/Secretary	39	9
	Assistant manager	23	5
	Manager	47	10
	CEO general manager	28	6
	Self employed	170	38
	Total	**450**	**100**
Religion	Christian	379	84
	Islamic	71	16
	Total	**450**	**100**

Source: Own construction.

Table 5.4 shows the demographic profile of the 450 respondents selected for this study. According to Table 5.4, fifty four percent (54%) of respondents were male and forty six percent (46%) were females. Thirty eight percent (38%) of respondents belonged to the age group of 30-39, whilst the lowest percentage of three percent (3%) was 60 years of age and above. Thirty four percent (34%) of respondents belonged to 0-29 years age group, nineteen percent (19%) were 40-49 years of age and six percent (6%) were 50-59 years of age.

Respondents earning a monthly income of ₦21,001–₦40,000 and ₦41,001-₦60,000 had the highest percentage of sample representation of nineteen (19%) respectively, followed by sixteen percent (16%) of respondents earning a monthly income in excess of ₦120,000. Nine percent (9%) of respondent earned a monthly income between ₦101,001 and ₦120,000, twelve percent (12%) earned a monthly income between ₦1,000-₦20,000 and fourteen percent (14%) earned a monthly income between ₦ 61,001-₦80,000. Eleven percent (11%) of sample representation earned a monthly income between ₦81,001-₦100,000. Furthermore, forty nine percent (49%) of respondents were married, forty six percent (46%) were single and three percent (3%) were divorced. The widowed and co-habitant had the lowest representation percentage of one percent (1%) respectively.

Three percent (3%) of respondent had a family size of above eleven. Forty four percent (44%) of respondents had a family size of 2-4, thirty three percent (33%) had a family size of 5-7 and seven percent (7%) of respondents had a family size of 8-10. Thirteen percent (13%) of respondents had a family size of 1. Eight percent (8%) of respondents attained a secondary school certificate, whilst the majority of thirty seven percent (37%) had a post-graduate degree. Thirty four percent (34%) had acquired an undergraduate degree, seventeen percent (17%) had diploma and four percent (4%) had other qualifications. A total of five respondents indicated that they had no formal education (1), primary education (2) and junior secondary education (2).

Nine percent (9%) of respondents' nature of field of business was manufacturing, whilst the majority, fifty percent (50%), were involved in services delivery. Eleven percent (11%) of respondents were involved in wholesaling, ten percent (10%) were retailers and twenty percent (20%) were involved in nature of fields not listed. Thirty eight percent (38%) of respondents were self-employed and twenty one percent (21%) were general workers. Six percent of respondents (6%) occupied the CEO general position in their occupation, five percent (5%) were assistant managers, two percent (2%) were foremen and nine percent (9%) of respondents were supervisor and administration secretaries, respectively, while ten percent (10%) were managers. Eighty four percent (84%) of the respondents were Christians and sixteen percent (16%) were Muslims.

5.5 THE RESEARCH INSTRUMENT

The research (measuring) instrument is crucial for the purpose of collecting the primary data in a research study. The questionnaire, also called a survey instrument, is a set of well-structured questions, constructed by the researcher for the purpose of collecting primary data from respondents (Hair *et al*., 2003:448). According to Brace (2013:2), the questionnaire is referred to as a 'self-completion survey instrument' that is administered by the researcher either through face to face or through the telephone for the purpose of collecting data. Brace (2013:2) suggests that the use of a standardised questionnaire format assists the researcher in handling and interpreting data accurately.

Furthermore, Cant *et al*. (2005:131) reveal that the questionnaire is a research instrument that is used to collect primary data from respondents. Cant *et al*. (2005:131) suggest that in order to avoid common mistakes, the researcher should construct the questionnaire with precision. This means that researchers have to carefully construct the words, questions, format and hypotheses in a manner that respondents would comprehend. Therefore, a questionnaire that is constructed in a comprehensive manner is likely to generate accurate data from respondents and facilitate rapidity in data processing (Hair *et al*., 2003:449).

5.5.1 Questionnaire design and structure

The most common type of measuring instrument employed in a marketing research is a questionnaire (Cant *et al*., 2005:147). The questionnaire is used to collect primary data from respondents for the purpose of resolving an identified problem and meeting the research objectives. The manner in which the questionnaire is designed is crucial in achieving the aim of the research study. In other words, the manner in which every question or item in the questionnaire is constructed should be relevant and contribute towards achieving the objectives of the research project (Azzara, 2010:18). Furthermore, Cant *et al*. (2005:147) states that it is crucial for the researcher to concentrate on the accurate/detailed development, formulation and application of the questionnaire. The reason is that the questionnaire represents the only primary data collection package that is used to resolve the identified research

problem and when it is poorly constructed, the results of the analysis may be inaccurate.

Leedy and Ormrod (2013:194) support this notion by stating that a questionnaire should be carefully planned and constructed in order for the raw data gathered to provide accurate answers to the research questions. Leedy and Ormrod (2013:196-197) suggest that in constructing a suitable and precisely worded questionnaire that will encourage easy cooperation from respondents and smooth analysis and interpretation of data, researchers should consider the following twelve guidelines:

- the questions contained in the questionnaire should be short and include only questions relevant to the research study;
- the question in the questionnaire must be clear and simple for respondents to read and respond to;
- the questionnaire should contain instructions that are understood by respondents;
- the questions and language used in the questionnaire should be clear to respondents;
- the questions with unnecessary statement should be properly verified by the researcher;
- questions should not be formulated on the basis of unwarranted assumptions;
- questions must be formulated in a manner that will allow respondents to choose their desired response and not researcher's preferred response;
- questions in the questionnaire should be properly coded to ensure accuracy in the analysis of data;
- questions that relate to controversial topics should be consistent so that respondents can give a response that is socially acceptable rather than a response that creates favourable impression;
- the questionnaire should be pilot tested to determine its validity;
- the questionnaire that is ready for use must be properly scrutinized by the researcher to ensure its readiness to proffer solutions to the research problem and meet the research goal; and

- the questionnaire should be attractive and professional.

Furthermore, questions contained in the questionnaire can be unstructured questions (open-ended questions) and structured questions (closed-ended questions) (Hair *et al*., 2003:450). According to Grover and Vriens (2006:86), unstructured questions in a questionnaire are open-ended when they allow respondents to provide their own answers in their own words. The unstructured questions are mostly employed by researchers conducting exploratory research and they provide rich and in-depth information regarding the opinions as well as attitudes of respondents when administered correctly (Hair *et al*., 2003:450).

The use of an open-ended questionnaire can, however, be a disadvantage because of the interviewer error (responses are not understood by the researcher or are recorded incorrectly), it accrues cost, it is difficult to code and analyse, interviewers may be biased (presenting data that was not gathered from participants) and it requires great skill in collecting data and understanding the actions of participants (Grover & Vriens, 2006:86). The structured questions in a questionnaire are closed-ended questions that make questions available to the respondent and specify a possible range of permitted response in a scale (Grover & Vriens, 2006:86). According to Zikmund and Babin (2010:199), the structured questions provide respondents with limited number of responses to items.

Adhering to the guidelines of the development of a measuring instrument by Leedy and Ormrod (2013:196-197), this study developed a structured questionnaire (closed-ended questions) for the purpose of gathering primary data in this study. The structured questionnaire (closed-ended questions) was used because it was easy to code, it was easy for respondents to answer, it enabled quickness in data analysis and it discouraged the researcher from being bias (Grover & Vriens, 2006:87).

5.5.2 Measuring instrument scales

The items of the questionnaire were both self-developed or collected from previously used scales. The items collected from prior research were rephrased to avoid plagiarism and to adapt them to the objectives of this study. Furthermore, the questionnaire was assessed by the research coordinators (expert judgment) from the Department of Business Management in Nelson Mandela Metropolitan University and it was edited by a language editor to avoid language errors.

The questionnaire used for the purpose of gathering the primary data in this study was designed in three segments, namely, the cover letter, Section A and Section B. The cover letter of the questionnaire introduced the study and objectives of the study to respondents. Section A had 105 items on a 5-point Likert scale (1=strongly disagree, 2=disagree, 3=indifferent, 4=agree and 5=strongly agree) and it measured the predisposing factors, enabling factors, consumer decision-making process, customer satisfaction and cognitive dissonance. The one hundred and five items formulated in Section A of the questionnaire measured the variables and its attributes. The variables, attributes and the sources from which the items were adapted from will be discussed to clarify them. Section B contained the biographical information of respondents.

5.5.2.1 Predisposing factors

The predisposing factors are independent variables in this study. This study defines predisposing factors as individual characteristics that determine or influence the client's decision-making process regarding the utilisation of health care services from a private health institution. The predisposing factors in this study had three variables, namely, the client's demographics, social structure and beliefs. These variables had attributes that were all measured by varying number of items linked to a 5-point Likert scale.

(a) **Demographics** had three attributes, namely, age, gender and marital status. Age, gender and marital status were all measured separately using seven items that were linked to a 5-point Likert scale. Items on gender were

adapted from the work of Bergman, Larsman and Love (2014:199). Age was adapted from the work of WHO (2008:6-13) and the items used measuring marital status were self-developed by the researcher.

(b) The **Social structure** of client had four attributes, namely, education, occupation, family size and religion.

Education in this study refers to clients' level of schooling, enlightenment in the utilisation of health care services and how it influences health care utilisation from the private health institutions. Education was measured by using eleven items that were adapted from Hudelson, Perneger, Kolly and Perron (2012:4).

Occupation in this study refers to clients' line of work or profession and how it influences the utilisation of health care services from the private health institutions. Occupation was measured by using five items and that were adapted from Furnham, Eracleous and Chamorro-Premuzic (2009:770).

Family size in this study refers to the number of persons that dwell within a household and how it influences the purchase of health care services from the private health institutions. Family size was measured by using five items that were adapted from WHO (2008:6-13).

Religion in this study refers to a clients' faith, belief and level of spirituality and how it influences the purchase of health care services from the private health care institution. Religion was measured using five items that were adapted from Aflakseir and Coleman (2011:53) and Huber and Huber (2012:717).

(c) **Beliefs** in this study refers to a clients' personal conviction, perception or views regarding the utilisation and services of private health institution, health insurance, traditional methods of health care and patent medicine sellers. This study proposes that the beliefs of clients influence health behaviour as it influences their purchase of health care services from the

private health institution. Belief was measured using ten items that were self-developed.

5.5.2.2 Enabling factors

The enabling factors are independent variables in this study and it refers to the resources that will enable clients to utilise or access the private health institution. In other words, the enabling factor enables entry and ensures treatment to a client in the private health institution. Enabling factors are made up of three variables, namely, personal income, health insurance and family financial support.

(a) **Personal income** in this study refers to a client's total compensation or earning received during a specific period. This study proposes that a client's personal income will influence a client's utilisation of health care services from a private health institution. Personal income was measured using six items that were self-developed by the researcher.

(b) **Health insurance** in this study refers to a medical insurance coverage that is responsible for paying the health expenses that are incurred by the covered client. This study proposes that health insurance influences a client's utilisation of health care services from a private health care institution. Health insurance was measured using eight items which were adapted from Ulbinaite, Kucinskiene and Le Moullec (2013:148-149).

(c) **Family financial support** in this study refers to the financial aid or support that clients receive from family members as a result of using health care services from a private health institution. Family financial support was measured using five items which were adapted from the work of Larson, Goldberg, McDonald, Leuchovius, Richardson and Lakin (2011:38).

5.5.2.3 Consumer decision-making process

Consumer decision-making process is a mediating variable in this study. The consumer (client) decision-making process refers to the stages that clients pass

through in order to make a decision to utilise health care services from a private health institution. This variable was measured using nine items linked to a 5-point Likert scale. The items that were used to measure the consumer decision-making process were adapted from Heggland, Øgaard, Mikkelsen and Hausken (2012:5-6) and Spicer and Sadler-Smith (2005:144).

5.5.2.4 Customer satisfaction

Customer satisfaction is a dependent variable in this study. It refers to client's affirmation that their overall experiences of the health care services purchased from the private health institution meet or exceed their expectation. Customer satisfaction was measured using twelve items that were linked a 5-point Likert scale. These items were adapted from the work of Butt and Cyril de Run (2010:662) and Webster, Mantopoulos, Jackson, Cole-Lewis, Kidane, Kebede, Abebe, Lawson and Bradley (2011:261-262). Their research focused on customer expectation and perception of private health care quality and patient's health care experiences in a low-income setting.

5.5.2.5 Cognitive dissonance

Cognitive dissonance is a dependent variable in this study. This study defines cognitive dissonance as the doubt, feeling of remorse, disapproval, unhappiness or anxiety that a client experiences after the purchase of health care services from a private health institution. In other words, when the overall services received (actual experience) by client do not meet or exceed their expectations, they experience cognitive dissonance. Cognitive dissonance was measured using the seven items on a 5-point Likert scale that were adapted from the study of Hamza and Zakkariva (2012:159-160) and Kim and Moon (2009:154).

Section B of the measuring instrument (questionnaire) consisted of the biographical information of respondents and had nine close-ended questions using nominal scales.

Gender was measured as a single item using a two-point scale, namely:

Male = 1

Female = 2

Age was measured using a four-point scale situation ranging from:

20-29 = 1

30-39 = 2

40-49 = 3

50-59 = 4

60+ = 5

Monthly income was measured with a seven-point scale, namely:

₦1,000-₦20,000 = 1

₦21,001-₦40,000 = 2

₦41,001-₦60, 000 = 3

₦ 61,001-₦80,000 = 4

₦81,001-₦100,000 = 5

₦101,001-₦120,000 = 6

₦120,001 and above = 7

Marital status was measured with a five-point scale situation and was itemised as:

Single = 1

Married = 2

Divorced = 3

Widowed = 4

Co-habitat = 5

Family size was measured using five-point scale, namely:

1= 1

2-4= 2

5-7= 3

8-10= 4

11+= 5

Level of education was measured using eight-point scale, namely:

No formal education = 1

Primary school = 2

Junior secondary = 3

Secondary school = 4

Diploma = 5

Undergraduate degree = 6

Post-graduate degree = 7

Others please specify = 8

Nature of field was measured using a five point scale, namely:

Manufacturing = 1

Retailing = 2

Wholesaling = 3

Services = 4

Other = 5

Occupation was measured using an eight-point scale, namely:

General worker = 1

Supervisor = 2

Foreman = 3

Admin C/Secretary = 4

Assistant manager = 5

Manager = 6

CEO General Manager = 7

Self-employed= 8

Religion was measured using a two scale situation, namely:

Christian = 1

Islamic = 2

5.5.3 Level of measurement

The level of measurement employed in the measuring instrument (questionnaire) is significant with regards to the type of statistical analysis that will be used to summarise and present the data (Lind *et al*., 2006:9). According to Wood and Kerr (2010:103), the level of measurement is used to collect primary data and it determines how the primary data is collected and analysed. Prior to the collection of the primary data, Healey (2011:13) and Wood and Kerr (2010:103) suggest that the researcher should understand what each level of measurement entails, how they are used and what their contribution to the research plan is because it tells the researcher which statistics is appropriate to use in the research study. According to Rubin (2012:23), the four levels of measurement scales that can be employed when conducting a research study are ordinal, ratio interval and nominal scales.

Ordinal scales refer to a scale of measurement in which items are ranked or categorised according to the order of magnitude. In other words, it reflects order in measurement. Ranking satisfaction, for example, on a scale of one to seven means that satisfaction is high when ranked as seven. Ratio scale refers to the scale of measurement in which a fixed zero value exists. The fixed zero value point refers to that point where what is being measured means nothing and the intervals of measurement are equal (Le Roy, 2012:56-58).

Interval scales refer to a scale of measurement where differences between scales points exist, have the same meaning and are equal (Rubin, 2012:17). Wood and Kerr (2010:105) refer to the interval scale as a quantitative numeric scale where numbered intervals between points are equidistant. The categories are ranked on a scale and the distance that exist between each category that is known and the ranking of these categories are proportionate (Denscombe, 2003:238). According to Healey (2011:12), the ranking of variables and the distance from each score is known and equal in the interval scale.

The measuring instrument (questionnaire) that was used in this study was divided into two sections namely, Section A (interval scales) and Section B (nominal scales). Section A of the measuring instrument (questionnaire) contained items on a 5-point

Likert scale that ranges from strongly disagree to strongly agree. The Likert scale allows respondents to read questions/statements about a construct and provide optional answers specified in the questionnaire. The use of a Likert scale is easy to understand and to administer and will assist the respondent to answer questions in a trouble-free way (Zikmund & Babin, 2012:265). Specifically, questions that are based on the respondents' demographics, social structure, income, beliefs, health insurance, family financial support and respondents' satisfaction or cognitive dissonance regarding their utilisation of private health institution will be asked in section A of the questionnaire.

Nominal scales involve the use of words or numbers for the classification or labeling of items. These numbers or words that are used in classifying the items are meaningless because they are basically used for the purpose of coding the items and distinguishing the properties in the items (Denscombe, 2003:237). Sim and Wright (2000:170) support this notion by affirming that the nominal scales are the lowest level of measurement and the numbers and words assigned to them are meaningless and they are used for labeling or coding purposes. Furthermore, Sim and Wright (2000:170) state that the numbers assigned to the category do not affect the information that will be gathered and have no quantitative meaning but represent a category into which a person, an object or item can be classified.

Wood and Kerr (2010:104) report that the nominal scales allow events, people or objects that differ from themselves to be classified into two or more categories. The classification of these categories is mutually exclusive and allows all variables to be classified appropriately. This indicates that, each respondent must fit into a stipulated category of a given statement. For example, in the classification of gender, a respondent falls into a category of 1 = male or 2 = female (Wood & Kerr, 2010:104). Section B of the measuring instrument (questionnaire) in this research study contained biographical information of respondents. Biographical information such as respondent's gender, age, level of education, religion, monthly income, marital status, occupation and family size was covered in section B of the questionnaire.

5.5.4 Reliability and validity of the measuring instrument

Reliability and validity are essential for good measurement in a quantitative study. The reliability and validity test on a measuring instrument (questionnaire) ensures that results are true and errors are minimised. Reliability and validity create a difference between a good research and a bad one (Wood & Kerr, 2010:220). According to Salzberger (2009:25), reliability and validity ensure that the measure is purified to reflect the empirical character of measurement. It is also aimed at identifying malfunctioning items.

According to Cant *et al*. (2005:234), reliability and validity of the measuring instrument ensure the trustworthiness of any research study. Furthermore, the trustworthiness in a research study depends, largely, on the data collection procedure, measurement procedures and assessment procedures (Roberts & Priest, 2006:41). Reliability and validity reduce flaws in the measurement procedure and promote a more reliable and valid measure of the characteristics that are being measured (Cant *et al*., 2005:234). Leedy and Ormrod (2013:89) put forward that the reliability and validity of the measuring instrument are crucial in order to have a sound research conclusion and they determine if the researcher will obtain statistical significance in the analysis of data or not.

Reliability refers to the extent to which a measuring instrument such as a questionnaire, any measuring procedure, test and observations produce consistent results if repeated continuously (Leedy & Ormrod, 2013:91). Similarly, Bell (2005:117) postulates that reliability is the extent to which a test is or procedures are capable of producing results that are similar under constant conditions. McDaniel and Gates (2006:222) suggest that when measuring scales or other measurement devices produce the same result over time, it can be said to be reliable. In this context, reliability of the measurement scale provides consistent results that are free from random error (McDaniel & Gates, 2006:222). Thus, a consistent result obtained by using the same measuring instrument on the same individual or object over time is referred to as reliability. Bell (2005:117) adds that the reliability of a measuring instrument is crucial at the stage of questionnaire construction (question wording) and piloting of the instrument.

Barry *et al*. (2014:13) explain that there are several methods that can be employed by a researcher in assessing the reliability of a measurement procedure. These methods are test-retest reliability, internal consistency reliability, parallel form reliability and interrater reliability (Barry *et al*., 2014:13). In contrast, McDaniel and Gates (2006:222) suggest that the three ways of assessing the reliability of a measuring instrument are test-retest, equivalent forms and internal consistency.

The **internal consistency reliability** was employed for the purpose of assessing the reliability of the measurement procedure in this research study. According to Zeanah (2012:243), the extent to which the items of the measuring instrument (questionnaire) measures or reflect the same construct, is referred to as internal consistency reliability. Internal consistency reliability can further be explained as the extent to which the various items measuring a constructs, deliver consistent or similar scores when administered on separate occasions or it can be defined as consistency of the results delivered on test when administered on different samples at different times (McCrae, Kurtz, Yamagata & Terracciano, 2011:29). Furthermore, Miller (2013:2) puts forward that when individual items in the measuring instrument are highly correlated with each other, then the researcher should be confident about the reliability of the entire scale.

Salzberger (2009:24) further states that the Cronbach's alpha is a measure of internal consistency reliability. According to Salzberger (2009:24), Cronbach's alpha has to be computed for sets of items measuring each construct and items that reduce alpha have to be eradicated because they do not correlate with a set of items measuring a construct. According to Andrew, Pedersen and McEvoy (2011:224), coefficient alpha or the Cronbach's alpha technique is a popular method for the measurement of internal consistency reliability.

Andrew *et al*. (2011:224) describe the Cronbach's alpha as a technique that ensures that an item that does not correlate with or belong to a group of items measuring the same construct is omitted. In other words, the Cronbach's alpha ensures that different sets of items in a questionnaire measure their proposed construct. Andrew *et al*. (2011:224) suggest that Cronbach's alpha values will be high when the items

measuring the same construct are highly correlated. The Cronbach's alpha cut-off point of 0.6 is seen as desirable. It was used in assessing the reliability of the measuring instrument in this research study (Nunnally & Bernstein, 1994:252; Zeanah, 2012:243).

The extent to which the measuring instrument measures what it is intended to measure is referred to as validity. **Validity** ensures that the measuring instrument achieves its designed purpose (Andrew *et al*., 2011:224). Somekh and Lewin (2011:221) reveal that validity ensures that the measurement instrument collects the primary data that is required by the researcher to answer the research questions. According to Bryman (2012:47), validity ensures the correctness or credibility of the conclusion that is drawn from a research study. In addition, McDaniel and Gates (2006:224) stipulate that the validity of a measure is crucial in a research study because it ensures that the measuring instrument or procedure is useful and free from systematic and random error. Furthermore, Andrew *et al*. (2011:224) and Barry *et al*. (2014:13) propose three types of validity, namely, content validity, construct validity and criterion-related validity. The content and construct validity were used to assess the validity of the measurement scale in this research study.

Content validity is concerned with the degree to which items on the measuring instrument (questionnaire) are a representative samples of the universe of content or it is the extent to which the items on the measuring instrument address the topic of researchers' interest (Cottrell & McKenzie, 2010:312). According to Krishnaswamy, Sivakumar and Mathirajan (2009:265), content validity is the extent to which the measuring instrument provides total coverage or sufficient information on the topic that is researched. Krishnaswamy *et al*. (2009:312) further argue that the measuring instrument can be concluded to have a good content validity when it sufficiently covers the topics that have been defined as the relevant dimensions. Content validity refers to the extent to which the measurement items or scale reflect the concept that is measured by the researcher (Zikmund & Babin, 2010:336).

Krishnaswamy *et al*. (2009:312) put forward that content validity can be carried out by the researcher in two ways, depending on the type of research design used in the study. Firstly, the researcher should determine the validity by providing a

comprehensive definition of the topic that is being studied, the items to be scaled and the scales that will be used. Secondly, the researcher should determine the content validity by using experts that are knowledgeable about questionnaire construction and validity. These experts will assess the measuring instrument and advise if the measuring instrument is up to standard. In order to ensure the content validity in this study, the measuring instrument was assessed by ensuring that the measurement items represent the concept that is being studied. It was assessed by the research experts/coordinators from the Department of Business Management in Nelson Mandela Metropolitan University.

Construct validity is an analytical way of ensuring the validity of a measuring procedure. In other words, construct validity is concerned with the degree to which the measuring device or procedure measures the theoretical construct or concept of the study (it ensures that the test is measuring the construct it was meant to measure). Construct validity accesses the validity of a measuring procedure and ensures that the construct in a study is truly measured (Wilson, 2010:120). According to Gebotys (1999:1-2), construct validity aims at analysing data through the following procedures that include, correlations between test scores and designated criterion variables, differentiation between groups, factor analysis, multitrait-multimethod matrix analysis, and analysis of variance components within the framework of generalisability theory.

According to Burns, Burns and Burns (2008:430), construct validity can measure the hypothetical construct through the process of Cronbach's reliability coefficients and factor analysis. Measuring the hypothetical variables through the process of reliability indicates that the items must be internally consistent and factor analysis ensures the measurement of the construct (a large common factor). The reliability (internal consistency) of items as well as items and composite variables created from them is essential because it creates a support on the construct validity of a set of items on a scale. Burns *et al*. (2008:430) suggest that the rule of thumb for inter-correlated items should exceed 0.30. The inter-correlated items of 0.40 (factor loadings) and above were considered significant in this study.

Construct validity is made up of several components, such as face, content, criterion, convergent and discriminant validity (Zikmund *et al*., 2012:304). Discriminant validity was used in this study to assess the distinctness of the measures of different concepts or constructs. In order words, discriminant validity was used in assessing and testing low correlations that exist among measures of a construct (Harrington, 2008:6).

Furthermore, Construct validity was carried out in this study by running empirical test through the process of exploratory factor analysis (EFA). In order to achieve construct validity, this study employed exploratory factor analysis for obtaining factor loadings, eigenvalues and communality for the solution of the hypotheses. EFA refers to the statistical way of studying the dimension and analysing the interrelationships among a given set of variables in a study. Factor analysis aims at describing the variability among the observed and correlated variables by explaining the relationships in terms of a reduced number of variables called factors. Factorial validity is a part of construct validity that is established through the process of factor analysis (Gebotys, 1999:1-2).

5.5.5 Pretesting and administration of the questionnaire

Conducting a pilot study on the measuring instrument before it is deployed on the actual sample of researcher's interest is crucial in a research study. According to McBurney and White (2009:236), the pilot study is a small scale study that is carried out by the researcher to modify the study designs and procedures. McBurney and White (2009:236) assert that a pilot study corrects mistakes in the measuring instrument, helps create excellent designs and improves credibility of the findings when deployed on a larger sample size. According to Yin (2011:37), a pilot study is not directed to fix only mistakes in the data collection instrument but it is also aimed at testing and refining other aspects of the research study such as the design, field work, procedures and analysis plans.

Further, Blessing and Chakrabarti (2009:114) argue that running a pilot study is imperative, because it is aimed at improving the quality and validity of the results and helps to avoid the difficulties associated with the analysis of data. Cant *et al*.

(2005:157) suggest that it is imperative for a newly constructed questionnaire to be pretested, as it improves the “content, phrasing, sequence, layout, intuitiveness, and instructions” of the questionnaire. The aim of the pilot study is to help the researcher to discover and fix mistakes in the research instrument before it is used on the targeted sample size (Cant *et al*., 2005:156).

The measuring instrument (questionnaire) was tested on a small number of respondents from the selected sample size drawn from the population. The questionnaire employed for this research study was self-administered. Respondents were given time to complete the questionnaires at their convenience. The researcher also provided additional information to respondents regarding the research study. This approach helped minimise errors on the primary data which was gathered (Cargan, 2007:116).

5.6 DATA COLLECTION METHOD

The collection of data is crucial after the formulation of the research problem, the identification of the research design and the construction of the measuring instrument. The two types of data that can be collected to solve problems identified in a research study are the secondary and primary data (Kothari, 2004:95). According to Thyer (2010:168), the secondary and primary data complement each another. This indicates that the secondary data defines the agenda for which the research questions can be formulated and it requires the collection of the primary data for which the research questions formulated can be answered. Furthermore, Thyer (2010:168) reports that the secondary data apply the use of existing data to proffer solutions to specific research problems and fills the gaps in the knowledge base, whilst the collection of primary data produces new knowledge and fills current gaps. The secondary data and primary data were collected to achieve the purpose of this research study.

5.6.1 Secondary data collection

Secondary data are data that already exist. Secondary data are the wealth of published external data that have been made available by other researchers to proffer solutions to their own research problems (Churchill & Iacobucci, 2009:171). Kothari (2004:111) postulates that secondary data are historical or pre-existing data (published or unpublished data) that have been gathered and analysed by other researchers. According to Churchill and Iacobucci (2009:171), the advantage of secondary data is that it is cheap and can be collected quickly. Mooi and Sarstedt (2011:29) support this notion by stating that secondary data can be accurate, gathered at low cost, easily accessed and easier to compare with other research that has used similar data.

Due to the vast availability of secondary data, Churchill and Iacobucci (2009:171) suggest that researchers should carefully gather and present secondary data in a comprehensive form and concern themselves with the quality and accuracy of the secondary data gathered so as to meet the aim of the research study. Furthermore, Kothari (2004:111) reveals that the use of secondary data is risky and it should only be gathered if it relates to the research concern, and if it is reliable, suitable, adequate and authentic. Hair *et al*. (2003:100) provide six fundamental principles that will guide researchers in gathering secondary data, these are:

- **Purpose**: The researcher must have a set purpose why the secondary data must be collected. The secondary data must be critically evaluated so as to fit into the current research and achieve the purpose of why it was collected.
- **Accuracy**: Accuracy in the collection of secondary data is significant. The current researcher must focus on what was actually measured before gathering useful information from the source. The sources of data gathered (when it was gathered, how it was gathered, where it was gathered and from whom it was collected from) must be assessed critically by the researcher to ensure precision. In collecting secondary data, the researcher must exercise caution because the data collected from secondary sources was meant to address the researcher's own problems and objectives.

- **Consistency**: Researchers should gather information from several sources of similar data that are relevant to the study.
- **Credibility**: Researchers must take time to assess the trustworthiness of the data, researcher's reputation and its technical proficiency before the data gathering.
- **Methodology**: The researcher must give consideration to the methodology that will be employed in gathering the secondary data. This approach will assist the researcher in order to avoid errors in gathering the primary data.
- **Bias**: Researchers must understand the rationale why the information was published. This approach will assist the researcher to gather useful information from secondary sources that was not meant to incite or advance other secondary sources.

Nykiel (2007:25) suggests that secondary data should be thoroughly gathered before the primary date, because it provides the researcher with sufficient information on the research study and it provides a basis for the collection of the primary data. Nykiel (2007:25) asserts that the secondary data can be collected from third party sources such as government agencies and research publications. Specifically, the secondary data in this study was gathered through the Nelson Mandela Metropolitan University library. Secondary data relating to the topic on discourse was gathered from journal articles, academic publications, newspapers, government publications, text books and reliable websites.

5.6.2 Primary data collection

The test of hypotheses and answers to research questions may require researchers to go beyond the use of existing or historical data (secondary data) into gathering and using of raw or primary data. This indicates that it is important for the researcher to go beyond collecting existing data into gathering new data that will provide answers to research questions and contribute to existing knowledge (Stevens, Wrenn & Loudon, 2012:117). Primary data are original data gathered by a researcher for the first time (Kothari, 2004:95). Wild and Diggines (2010:34) confirm that the primary data are first hand data that are gathered by a researcher to proffer

solution to research problems. In other words, they are data that have not been collected previously and that, when collected, must be filtered by original research.

Furthermore, primary data are data that are gathered for a specific research problem and one of the advantages of the primary data is that they are recent and directed to a specific research purpose (Mooi & Sarstedt, 2011:29). Churchill and Iacobucci (2009:171) state that when the secondary data gathered is not capable of resolving research problems, the researcher should proceed with collecting the primary data. According to Hair *et al*. (2011:185), researchers gather primary data by means of interviews, observation and questionnaire to examine the behaviour, beliefs, lifestyle, demographics and expectations of consumers. Similarly, Wild and Diggines (2010:34) affirm that the primary data can be collected through observation, experiments or survey (communication) and each method employed by the researcher is influenced by the type of the research that is carried out, research objectives, the availability of time, funds, staffs and facilities.

The method of gathering the primary data in this research study was by the survey or communication means. This indicates that questionnaires were administered to respondents in the Lagos state, Nigeria. The questionnaire was administered by the researcher and it was self-completed by the respondents themselves. The self-administered questionnaire was adopted by the researcher in this study because according to Seale's (2012:184) suggestions, it is cost effective to administer, there was greater speed in gathering data, it gave the researcher the advantage of a wider geographical coverage in administration and it increase the reliability of respondents' response due to the absence of the researcher.

5.7 DATA ANALYSIS

Data analysis is a crucial step in a research process that reduces large amount of primary data gathered into meaningful interpretation. In other words, data gathered and analysed are reduced into meaningful interpretation and further determine if the research questions were answered (Blaikie, 2003:28). According to Hair *et al*. (2011:294), the process by which statistical and logical technique is used by the researcher in describing and illustrating data is referred to as data analysis.

Hair *et al*. (2011:294) state that numerical data or information has to be quantified for researchers to proffer answers to the research questions. McGivern (2009:428-430) concurs that the aim of data analysis is to extract meaningful insights from large amounts of primary data gathered and produce credible findings that will provide answers to the research questions. Thus, data analysis involves running statistical test on data, presenting it in figures, tables and charts and it is directed at providing solutions to specific research study and knowledge advancement.

McGivern (2009:428) further explains that the process of data analysis in a quantitative research study involves sorting, organising, interpreting, summarising and reporting data that is gathered via the measuring instrument. According to Blaikie (2003:29), the methods by which the primary data can be analysed are univariate, bivariate, explanatory and inferential descriptive analysis. Similarly, Zikmund and Babin (2010:491) find that raw data gathered can by analysed by means of the descriptive analysis, univariate analysis, bivariate analysis and multivariate analysis.

The primary data gathered in this study was statistically analysed, using the Statistica package (Version 12) software. The analysis of the primary data gathered was analysed in five stages, namely, exploratory factor analysis, reliability of the measuring instrument, descriptive statistics, multiple regression analysis, and correlation analysis (Pearson correlation). The five stages of the methods used in analysing the data collected will be explained.

5.7.1 Exploratory factor analysis (EFA)

The first stage of the analysis of the data collected was EFA. The EFA was used to assess the variability amongst observed correlated items in the research instrument. According to Cramer (2003:13), EFA is a technique that groups all variables that are related together so that they can be treated as a joint variable rather than a series of separate variables. Fabrigar and Wegener (2012:3) state that the EFA refers to a statistical approach that is designed to determine the “number of distinct constructs needed to account for the pattern of correlations among a set of measures”. The EFA is aimed at examining the internal reliability of a measure (it identifies if all items

measuring a construct are highly correlated and be regarded as a joint scale). Therefore, an EFA investigates the theoretical construct or factors that might be represented by a set of items and assesses the quality of individual items and their contribution to a common factor (Blaikie, 2003:220).

5.7.2 Reliability of the measuring instrument (Cronbach's alpha)

The reliability of the measuring instrument was carried out at the second stage of data analysis. Reliability is the extent to which the measuring instrument produces consistent results when it is administered consistently on the same respondents (Blaikie, 2003:219). According to Blaikie (2003:219), the most common procedure used in testing scale reliability is the Cronbach's alpha. The coefficient ranges between the value of 0 and 1, and a high value coefficient indicates a high level of consistency among the items.

Zeanah (2012:243) states that a Cronbach's alpha of 0.70 or greater is considered to have good and satisfactory internal consistency reliability. In contrast, Salkind (2010:162) disagrees by saying that a Cronbach's alpha of 0.60 can be accepted when the researcher is exploring group differences in the area of personality characteristics. Leimeister (2010:140) supports this notion by stating that a Cronbach's alpha of 0.70 is considered to be good and a Cronbach's alpha of 0.60 is acceptable when conducting an exploratory research. Furthermore, Hair, Black, Babin, Anderson and Tatham (2006:102) state that a Cronbach's alpha of 0.60 is considered as satisfactory and sufficient value. Therefore, a Cronbach's alpha of 0.60 or greater was used as a cut-off point in assessing the reliability of the measuring instrument in this research study. The assessment of reliability enabled the measures to be free from random errors and ensured that the measuring instrument provided consistent data (McDaniel & Gates, 2006:222).

5.7.3 Descriptive statistics

The third stage of data analysis was the descriptive statistics which enabled gathered data to be organised, summarised and presented in an informative way. Descriptive statistics also reduced the large amount of data gathered and analysed into a summarised and meaningful form. This approach of data analysis presented

the summarised data into percentages, frequency tables and frequency distribution (Argyrous, 2005:123). According to Somekh and Lewin (2011:226), frequency distribution describes summarised data indicating the frequency of all categories in tabular form or graphical form (bar charts, histogram).

Lind, Marchal and Wathen (2012:58) state that descriptive statistics is concerned with how summarised data can be described in two numerical ways, namely, measures of location and measures of dispersion. According to Somekh and Lewin (2011:226), the measure of location refers to central tendency. The central tendency is the measures of the most typical value or central value in a frequency distribution that can be measured in three ways. Firstly, it can be measured by the mean (the average value derived when all values in the distribution is summed up and divided by the number of values in the data set), secondly, the mode (the most frequent value in a set of a given data) and thirdly the median (the center of all values after they have been organised from highest to lowest or vice versa).

Furthermore, the measure of dispersion in descriptive statistics shows the spread of data that can be measured in three ways namely. Firstly it can be measured by the range (difference between the highest and lowest value in a data set), secondly, by the variance (arithmetic mean of the squared deviation of the mean) and thirdly by the standard deviation (square root of the variance) (Lind *et al*., 2012:75-80). Somekh and Lewin (2011:276) state that when the data are clustered closely around the central tendency, the measure of dispersion has a small value and the mean is considered to be a representative of the data or there is similarity in the data. However, a large measure of dispersion indicates wide and diverse sets of responses. Furthermore, the measure of dispersion is aimed at comparing the spread of two or more distributions and evaluating the reliability of two or more measures of location (Lind *et al*., 2012:74-75).

5.7.4 Multiple regression analysis

The fourth stage of data analysis is the multiple regression analysis. Multiple regression analysis described and investigated the linear relationships that existed between several independent variables on a dependent variable (Argyrous,

2005:189). According to Blaikie (2003:146), multiple regression analysis explains what happens to the dependent variable (response variable) when two or more of the independent variable (predictor variable) changes.

5.7.5 Correlation analysis (Pearson correlation)

The final stage of data analysis was the correlation analysis (Pearson correlation) which measures the correlation between two variables. In other words, it measured the direction and strength of the linear relationship between the numerical values assigned to the variables in question (Weinberg & Abramowitz, 2008:135).

Correlation analysis (Pearson correlation) measured and described the strength and relationship between two interval-scaled or ratio-scaled variables (Lind *et al*., 2012:463). This stage of data analysis calculated, tested and reported the relationship between two variables using the Pearson correlation coefficient. The correlation coefficient of -1.00 indicates a perfect negative correlation, +1.00 means perfect positive correlation and 0 indicates a zero or no relationship between two sets of variables (Lind *et al*., 2012:463).

5.8 SUMMARY

The design and methodology chapter provided detailed discussions of the method or technique that was used by the researcher to conduct this research study. The paradigm of the research is referred to as a broad framework that comprises the researchers' set of belief and perception that is used to conduct an empirical investigation. Further, the research methods differ from the paradigm of the research study in that they are seen as the technique in which the research will be conducted. This chapter highlighted three types of research methodology namely, quantitative research method, qualitative research method and mixed methods research.

The quantitative research method was adopted as a technique for this research study. The use of the quantitative research method allowed the researcher to collect primary data by means of a measuring instrument (questionnaire) from respondents and secondary data from journal articles, books, reliable websites and newspapers

through the Nelson Mandela Metropolitan University library. Furthermore, the sampling process was discussed in this chapter and the several phases of the sampling process that the researcher needs to follow in selecting a sample size was discussed in detail. The primary data will be gathered from 450 respondents that utilise private health care institution from the Lagos state, Nigeria.

The research instrument used for gathering the primary data is a structured questionnaire (closed-ended questions) on a 5-point Likert scales ranging from strongly disagree to strongly agree). The level of measurement (nominal scale and interval scale) used for this study was also highlighted in this chapter. The validity and reliability of the measuring instrument (questionnaire) was discussed and it ensured the reduction of errors in the measuring procedures and it promoted trustworthiness of the research study. In discussing the analysis of data in this chapter, the Statistica package (Version 12) was used. The data will be analysed in five stages namely, exploratory factor analysis, reliability of the measuring instrument (Cronbach's alpha), descriptive statistic, correlation analysis (Pearson's correlation) and multiple regression analysis. The following chapter will discuss the empirical findings from the analysis aforementioned.

CHAPTER 6
THE EMPIRICAL RESULTS OF THE CLIENTS' DECISION-MAKING PROCESS REGARDING PRIVATE HEALTH INSTITUTIONS

6.1 INTRODUCTION

The previous chapters presented detailed information on prior research regarding the topic of discourse and it discussed extensively the research designs, methods, measuring instrument and methods by which the primary data was gathered and analysed. This chapter provides discussions (on the evaluation) of empirical results from the analysed data. This chapter will present the research hypotheses and objectives of the study. This chapter will provide information about the statistical procedures that were employed in analysing the data, the results of the validity and reliability of the measuring instrument and the results from multiple regression analysis and correlation analysis.

6.2 PRESENTATION OF THE RESEARCH HYPOTHESES AND OBJECTIVES OF THE STUDY

The research hypotheses formulated for this study are statements that provide direction by which the objectives of this study will be accomplished. This study seeks to investigate the perceptions of clients on the decision-making process regarding the utilisation of private health institutions. Therefore, in achieving the objectives, the alternate hypotheses were further formulated on the basis of the theoretical model developed for this study.

Figure 6.1 indicates the selected variables that will be investigated in this study. Based on the hypothesised model (Figure 6.1) for the decision-making process, the following research hypotheses are identified:

H^1: *There is a relationship between demographics and consumer decision-making process in a private health institution.*

H^2: *There is a relationship between social structure and consumer decision-making process in a private health institution.*

H^3: *There is a relationship between beliefs and consumer decision-making process in a private health institution.*

H^4: *There is a relationship between personal income and consumer decision-making process in a private health institution.*

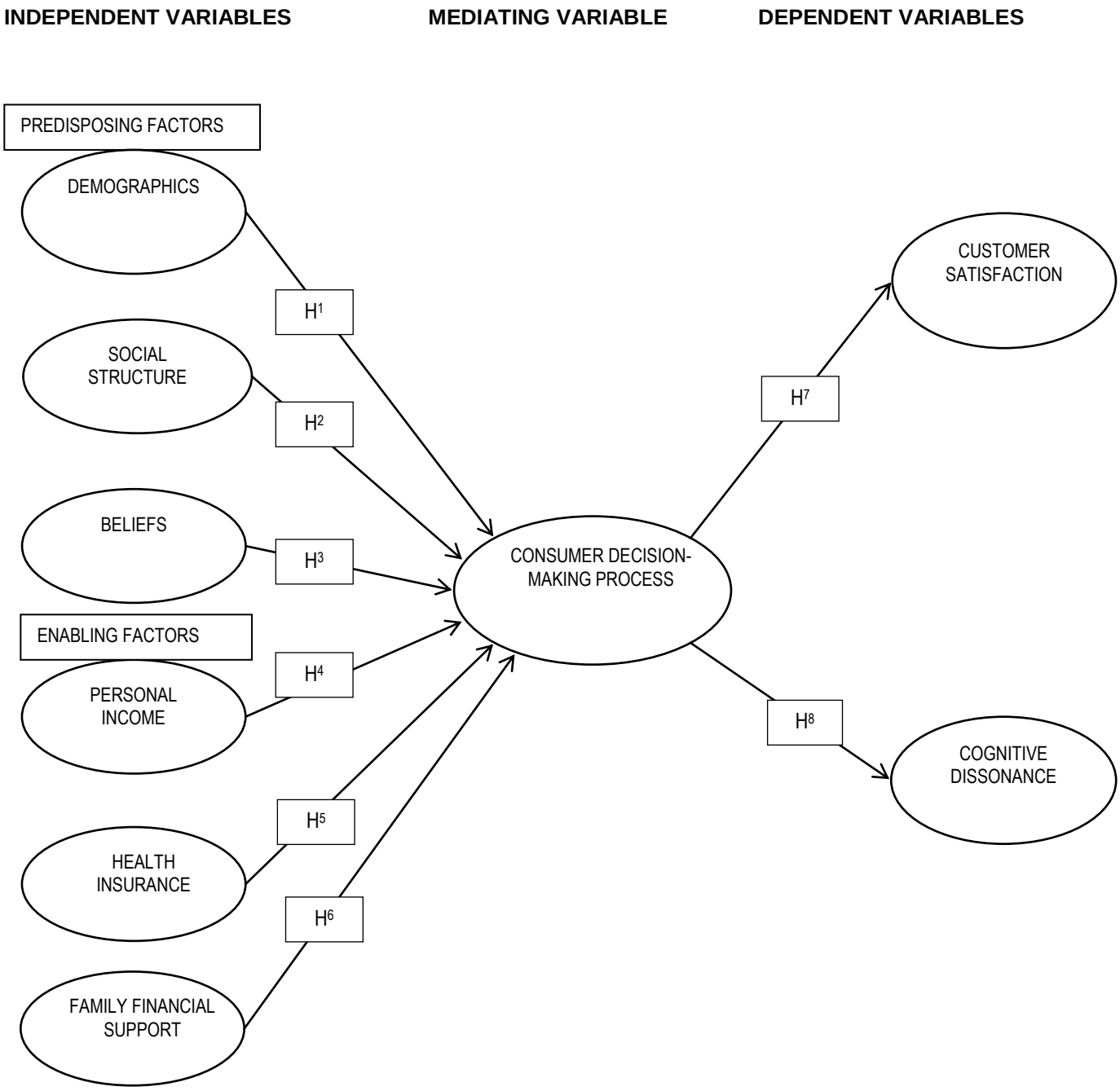
H^5: *There is a relationship between access to health insurance and consumer decision-making process in a private health institution.*

H^6: *There is a relationship between family financial support and consumer decision-making process regarding private health institution*.

H^7: *There is a relationship between the consumer decision-making process and customer satisfaction in a private health institution.*

H^8: *There is a relationship between the consumer decision-making process and cognitive dissonance in a private health institution.*

Figure 6.1: Theoretical model of the perceptions of the consumer decision-making process regarding private health institutions



6.3 DATA ANALYSIS RESULTS

The primary data gathered was statistically analysed by using the software Statistica (version 12). The analysis of the data was performed in five stages and the empirical results from the analysis will be presented accordingly.

Stage one: The first stage of data analysis was the exploratory factor analysis which was aimed at testing the validity of the measuring instrument. In other words, it was aimed at identifying variability and the relationship amongst items of a construct by grouping them together.

Stage two: Stage two of the data analysis was the assessment of the reliability of the measuring instrument. This stage of data analysis measured the internal reliability of the measuring instrument and it computed the Cronbach's alpha value. Specifically, the reliability was aimed at assessing the consistency of the measuring instrument and the Cronbach's alpha value of 0.6 upwards was considered appropriate in this study.

Stage three: Descriptive statistics was the third stage of data analysis. Descriptive statistics enabled the analysed data (variables) to be summarised and described in two numerical ways, namely, measures of location (mean) and measures of dispersion (standard deviation). Furthermore, the biographical information of respondents was summarised and presented as frequency tables and percentages.

Stage four: The fourth stage of data analysis was the multiple regression analysis. This stage of data analysis described and presented empirical results regarding the relationships that exist between the several independent variables and the dependent variables.

Stage five: The fifth stage of analysis was the correlation analysis. The correlation analysis focused on evaluation of hypothesised relationships by using the Pearson product moment correlation coefficient.

Furthermore, in understanding the presentation of results of the analysed data in this chapter, it is important to note that the names of variables and attributes were abbreviated. Table 6.1 provides the abbreviations of these variables and attributes for clarity purpose.

Table 6.1: Abbreviations of variables

Predisposing factors		
Independent Variables	**Attributes**	**Abbreviations**
Demographics	Age Gender Marital status	PREA PREG PREM
Social structure	Education Occupation Family size Religion	PREE PREO PREF PRER
Beliefs	-	PREB
Enabling factors		
Independent variables		**Abbreviations**
Personal income		EFP
Access to insurance coverage		EFH
Family financial support		EFF
Mediating variable		**Abbreviation**
Consumer decision-making process		DMP
Dependent variables		**Abbreviations**
Customer satisfaction		CST
Cognitive dissonance		CD

Source: Own construction.

6.3.1 Validity of the measuring instrument

Content validity was used to assess the measuring procedures in this study and it ensured that the items of the measuring instrument capture the entire scope of the issue that is being measured in this study (Zikmund *et al*., 2012:304). Furthermore, content validity enabled the measuring procedure to be assessed by the research coordinators (expert judgment) from the Department of Business Management in Nelson Mandela Metropolitan University. This process enabled the items of the

measuring procedure to represent the issue that is addressed or measured in this study (Kumar, 2010:180).

Construct validity was used to evaluate and assess the quality of the measuring instrument in this study. Construct validity is the degree to which the measuring instrument truly represents and reliably measures the intended concept of the study (Burns *et al*., 2008:430). Zikmund *et al*. (2012:304) postulate that construct validity is made up of several components, such as, face, content, criterion, convergent and discriminant validity. Bajpai (2011:49) suggests that the convergent and discriminant validity must be focused on when addressing construct validity in a study.

Discriminant validity is a component of the construct validity that was used in this study to assess or test whether the measures of a construct produce scores that are not related to each other or to the scores attained from an unrelated measurement (Bajpai, 2011:50). According to Zikmund *et al*. (2012:305), discriminant validity reveals the uniqueness and distinctiveness of a true measure and shows that measures of a construct are unrelated to measures of a different construct. Furthermore, exploratory factor analysis (EFA) was used as a means of accessing the discriminant validity of the measuring instrument. EFA is an analytical way of studying and analysing the dimension and interrelationship among the set of variables in this study. EFA described the variability of correlated variables by means of factors (Zikmund *et al*., 2012:305).

- **Factor analysis**

Factor analysis refers to a statistical technique that is used in a quantitative study to estimate factors and study the dimensions of a set of variables. In other words, factor analysis adopts an approach that reduces large variables to a smaller set of summarised variables most of which are correlated together. Factor analysis employs an approach of analysing data that is present and demonstrates that a particular set of correlated factors is the only valid one (Sheth & Tigert, 2011:135-136). Hair *et al*. (2011:386) support this notion by stating that, factor analysis is a multivariate statistical technique that is useful in the investigation of the relationship

between variables as a means of reducing large number of variables into few interpretable factors.

Factor analysis was essential in this study as it assisted in identifying if the number of variables shared a linear relationship with a smaller number of unobservable factors and assisted to identify shared relationship and common elements among variables belonging to the same factor (Robins, Fraley & Krueger, 2009:424-427). Factor analysis provides a rigorous approach of analysis in relation to construct and content validity. In other words, factor analysis is a common method by which the construct and content validity can be investigated in situations where relationships amongst variables are not known (Krishnan & Ramasamy, 2011:1).

Furthermore, factor loadings in a factor analysis show the final set of factors that are correlated by means of extraction and enables the study to identify the components of a measure that belong together within a factor. Factor loadings assume values from +1.00 to -1.00 and a substantial loading of 0.4 and above was the rule of thumb in this study (Suen & Ary, 2014:186). Table 6.2 shows the factor loadings in respect of the clients' perceptions of the decision-making process.

Table 6.2: Factor loadings: Clients' perceptions of decision-making process

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
Items	**Personal characteristics (DEM1)**	**Health insurance membership (HIM)**	**Personal income (PI)**	**Accessibility (DEM3)**	**Support sources (SS)**	**Service encounter experiences (DEM2)**
PREB4	**0.648187**	0.140905	0.118656	0.077332	-0.035890	0.144052
PREB1	**0.606665**	0.253271	0.014468	0.007767	0.049616	-0.054682
PREB2	**0.601069**	0.013138	0.152716	0.041875	0.104353	-0.100676
PREF1	**0.588518**	0.063690	0.051786	0.073251	0.072823	0.191441
PREE10	**0.564771**	-0.003429	0.060443	0.090472	0.066394	0.189552
PREG4	**0.533782**	-0.054084	-0.085437	0.000788	0.270329	0.104813
PREE7	**0.492659**	-0.024153	-0.005578	0.211380	-0.088296	0.133336
PREE4	**0.478460**	0.068921	-0.050241	-0.050228	0.127919	0.353456
PREE11	**0.468586**	0.018412	0.057640	0.172456	0.022895	0.127133
PREB3	**0.456684**	0.316113	0.137871	-0.108362	-0.046436	0.275533
EFP3	**0.454834**	0.208828	0.089928	0.308712	-0.116402	0.024868
PREB5	**0.454208**	0.209378	0.086803	0.258757	-0.116269	-0.148083
EFH6	**0.440220**	0.232051	0.062967	0.095100	0.065723	-0.061829
PREO3	**0.424949**	0.287497	0.009759	0.392943	-0.034667	-0.044719
PREF3	**0.418547**	0.069527	0.219094	0.152340	-0.008861	0.090636
EFH5	**0.418128**	0.368326	-0.040027	0.154332	0.021388	-0.132337
PREG3	**0.413771**	0.133238	-0.106489	0.177299	-0.098428	0.130861
PREG6	**0.411866**	0.063424	-0.080279	0.040167	0.152427	-0.144162
PREE6	**0.402786**	-0.125315	-0.044060	0.177891	0.134573	0.052903
EFH8	0.160650	**0.650528**	0.066468	-0.005767	0.115437	-0.028735
EFH7	0.142457	**0.636174**	0.081793	-0.036812	0.029024	0.012453
EFH3	0.161976	**0.564551**	0.103087	-0.138353	0.056017	0.193711
EFH4	0.183877	**0.542612**	0.137668	-0.075872	0.012632	0.187542
EFH1	0.044401	**0.479226**	-0.005773	0.073014	-0.175606	0.221690
PRER2	-0.187213	**0.460350**	0.065555	0.230010	0.017974	-0.042987
PRER4	-0.057267	**0.457554**	-0.052218	0.051886	0.053230	0.037150
EFP2	-0.085688	0.146981	**0.713154**	-0.034009	0.037451	0.129939
EFP1	0.084941	0.112555	**0.674904**	-0.060581	0.032183	0.186996
EFP6	0.140429	0.005491	**0.608974**	-0.047540	0.074688	-0.097089
EFP4	0.367743	-0.210538	**0.539951**	0.107808	0.053006	-0.138293
EFH2	-0.135596	0.240119	**0.509332**	-0.171903	0.176967	-0.054067
PREA2	0.020453	-0.114041	-0.122876	**0.634613**	0.173478	-0.118379
PREA1	0.082261	-0.161910	-0.115685	**0.626698**	0.152720	0.021869
PREB9	0.183491	0.073850	-0.136443	**0.497727**	-0.092369	0.153137
PREB10	0.298043	0.025283	0.008402	**0.490607**	-0.173609	0.073731
PREB7	0.221790	0.286029	0.157066	**0.423432**	-0.141843	0.267910
PREM1	0.139266	0.018919	0.156938	**0.421996**	0.173784	0.114276
PREO5	0.321589	0.064303	0.279743	**0.414905**	-0.026111	-0.133157
PREM2	0.121497	0.003173	0.097657	0.198571	**0.505999**	-0.126955
PREE5	-0.012253	0.044779	0.114694	-0.055603	**0.485346**	0.103141

Table 6.2: Factor loadings: Clients' perceptions of decision-making process (cont.)

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
Items	Personal characteristics (DEM1)	Health insurance membership (HIM)	Personal income (PI)	Accessibility (DEM3)	Support sources (SS)	Service encounter experiences (DEM2)
EFF1	-0.024204	-0.021341	0.108288	0.013052	**0.485309**	0.008587
EFF4	0.015502	0.162388	0.247920	-0.036575	**0.465704**	0.034487
EFF3	0.211224	0.287606	-0.090405	0.092659	**0.411923**	0.162987
PREA5	0.112480	-0.023869	0.149087	0.024800	0.076170	**0.567731**
PREE2	0.197935	0.263044	-0.024903	-0.022099	0.002200	**0.476612**
PREM5	-0.029763	0.193449	0.051642	0.032840	-0.056003	**0.466774**
PREM3	0.100775	0.126845	-0.025061	0.141228	0.008718	**0.423494**
PREG2	0.011384	0.111989	-0.054709	0.162213	-0.101708	**0.421909**
PREE1	0.356921	0.088595	0.042326	-0.044267	0.086362	**0.410192**
PREA3	0.297009	-0.113529	0.073724	0.127848	0.025594	**0.401350**
PRER5	0.163624	-0.139937	0.075790	0.213934	0.214038	**-0.410330**
PRER1	0.180046	0.006498	0.034478	0.160547	0.288142	**-0.412361**
PREA4	0.185745	-0.003132	0.229415	-0.009019	0.017040	0.393991
PREE3	0.157536	0.267046	-0.050830	-0.072578	0.218179	0.385859
EFF2	-0.012261	0.320433	-0.015236	0.054788	0.388169	0.369879
PREA6	0.316171	-0.052962	0.064986	0.093272	0.227211	0.343421
PREG1	0.246812	0.128455	0.089993	0.036699	-0.071266	0.331540
PREB6	0.038563	0.370828	0.123050	-0.035093	0.017526	0.329352
PREM4	0.067627	0.081040	0.118685	0.289342	-0.228790	0.312515
PREF4	0.067744	0.287653	0.031573	0.108843	-0.076609	0.306826
PREO2	0.104989	0.377012	0.317827	0.129293	0.131728	0.166337
PREA7	0.390882	-0.214555	0.024248	0.033353	0.169150	0.137867
EFP5	-0.006776	0.380703	0.138194	0.297415	-0.175967	0.095237
PREF2	-0.010136	0.243835	-0.152347	0.352849	0.111133	0.085972
PREM6	-0.070688	0.132858	0.044681	0.071995	0.182592	0.083998
PREM7	0.170385	0.195674	0.161066	0.258110	-0.164895	0.061880
PREF5	-0.195500	0.197724	-0.209294	0.374244	0.194787	0.049770
PREO1	-0.080254	0.156571	-0.034121	0.142173	0.238713	0.009895
PREE8	0.234591	-0.030707	0.255737	0.136079	0.365476	-0.035712
PREG5	0.392871	0.202401	-0.023744	0.156418	0.235258	-0.150813
PRER3	0.358528	-0.137541	0.183854	-0.075930	0.306642	-0.151476
PREB8	0.108996	-0.006370	0.203057	0.242223	0.326773	-0.173381
EFF5	0.231935	-0.043896	0.287847	0.195025	0.329799	-0.180192
PREO4	0.246578	0.041349	0.339687	0.391150	0.094838	-0.206154
PREG7	0.329247	-0.064227	-0.152547	0.082263	0.207826	-0.279623
Expl.Var	6.752723	4.252396	3.157400	3.576413	3.006884	3.925310
Prp.Totl	0.088852	0.055953	0.041545	0.047058	0.039564	0.051649

Loadings of 0.4 and above were considered significant.

6.3.1.1 Perceptions of clients towards predisposing factors: Demographics, social structure and beliefs

Table 6.2 shows that respondents did not view demographics as a single construct. This means that respondents perceived demographics as a three-dimensional variable: demographics related to 'personal characteristics; 'service encounter experiences' and 'accessibility' loaded onto factor (1), factor (4) and factor (6) respectively.

Table 6.2 indicates that three (PREG3, PREG4, PREG6) of the seven items that were expected to measure 'gender', five (PREE4, PREE6, PREE7, PREE10, PREE11) of the eleven items expected to measure 'education', two (PREF1, PREF3) of five items that were expected to measure 'family size' and five (PREB1, PREB2, PREB3, PREB4, PREB5) of ten items that were expected to measure 'beliefs' loaded onto factor one (1). Table 6.2 further indicates that one (EFP3) of the six items expected to measure 'personal income' and two (EFH5, EFH6) of eight items that were expected to measure 'health insurance' as well as one (PREO3) of five items that were expected to measure 'occupation' also loaded onto factor (1). This implies that all items that loaded onto factor one (1) are termed 'demographics' (DEM 1) related to 'personal characteristics'.

Table 6.2 indicates that two (PREA3, PREA5) of the seven items that were expected to measure 'age', two (PREE1, PREE2) of the eleven items that were expected to measure 'education', one (PREG2) of the seven items that were expected to measure' gender', two (PREM3, PREM5) of seven items that were expected to measure 'marital status' as well as two (PRER1, PRER5) of five items that were expected to measure religion loaded onto factor six (6). This is termed 'demographics' (DEM 2) related to 'service encounter experiences'.

Table 6.2 further indicates that two (PREA1, PREA2) of seven items that were expected to measure 'age', three (PREB7, PREB9, PREB10) of ten items that were expected to measure 'beliefs', one item (PREM1) of seven items that were expected to measure 'marital status' as well as one item (PREO5) of five items that were

expected to measure occupation loaded onto factor four (4). These items are termed ‘demographics’ (DEM 3) related to ‘accessibility’.

6.3.1.2 Perceptions of clients towards enabling factors: Personal income, health insurance and family financial support

Table 6.2 reveals that five (EFH1, EFH3, EFH4, EFH7, EFH8) of the eight items that were expected to measure ‘health insurance’ and two (PRER2, PRER4) of the five items that were intended to measure ‘religion’ loaded together onto factor two (2). These items that loaded together onto factor two (2) are termed ‘health insurance membership’ (HIM). Table 6.2 indicates that four (EFP1, EFP2, EFP4, EFP6) of the six items that were intended to measure ‘personal income’ as well as one (EFH2) of the eight items that were expected to measure ‘health insurance’ loaded onto factor three (3). These items that loaded together onto factor three are termed ‘personal income’ (PI).

Table 6.2 further reveals that three (EFF1, EFF3, EFF4) of the six items that were intended to measure ‘family financial support’, two (PREE5, PREE9) of the eleven items that were intended to measure ‘education’ as well as one (PREM2) of the seven items that was expected to measure ‘marital status’ loaded together onto factor five (5). These items that loaded onto factor five (5) are termed ‘support sources’ (SS).

Table 6.2 indicates that items which were regarded as measures of ‘demographics’, ‘social structure’ and ‘health beliefs’ (PREA4, PREA6, PREA7, PREG1, PREG5, PREG7, PREE3, PREE8, PREM4, PREM6, PREM7, PREO1, PREO2, PREO4, PREF2, PREF4, PREF5, PREB6, PREB8, PRER3) and measures of ‘family financial support’ (EFF2, EFF5) as well as ‘personal income’ (EFP5) did not load to a significant extent ($p < 0.4$), leading to the deletion of these items.

Table 6.3 displays the factor loadings of the perceptions of clients towards the decision-making process and the outcomes of decision-making process.

Table 6.3: Factor loadings: Perceptions of clients towards decision- making process, customer satisfaction and cognitive dissonance

	Factor 1	Factor 2	Factor 3
Items	**Customer satisfaction**	**Cognitive dissonance**	**Decision-making process**
DMP3	**0.687357**	0.005870	0.103012
CST3	**0.665317**	0.133220	0.109062
CST12	**0.660713**	0.221381	-0.066532
CD2	**0.649654**	0.136392	-0.044111
CST5	**0.644353**	0.085617	0.079187
DMP1	**0.635437**	-0.043829	0.202784
CD1	**0.625236**	0.230145	0.000697
CST9	**0.597095**	0.046269	-0.011157
CST7	**0.592115**	-0.010770	0.247783
CST8	**0.580550**	0.032549	0.082044
CST2	**0.580399**	0.204988	0.218857
CST1	**0.577409**	0.186921	0.175749
CST4	**0.576076**	0.141749	0.094147
CST10	**0.549713**	0.265796	-0.040389
CD 3	**0.530531**	**0.403446**	0.039431
CD4	**0.520339**	0.368291	0.220539
CST11	**0.518580**	0.291115	-0.047861
DMP2	**0.498457**	-0.131294	0.035306
DMP4	**0.415947**	0.179918	0.246386
CD7	0.075468	**0.819292**	0.004164
CD8	0.124443	**0.795731**	0.001618
CD6	0.058151	**0.766796**	0.074477
CD5	0.247502	**0.432957**	0.294739
DMP8	0.192998	-0.046207	**0.699765**
DMP6	-0.137233	0.033142	**0.674741**
DMP7	0.072934	0.097171	**0.611189**
DMP9	0.099365	0.083644	**0.591391**
DMP5	0.279596	0.231327	0.378942
CST6	0.317142	0.140704	0.303897
Expl.Var	6.629059	2.761459	2.343315
Prp.Totl	0.236752	0.098624	0.083690

Loadings of 0.4 and above were considered significant.

6.3.1.3 Perceptions of clients towards decision-making process and outcomes of decision-making process

Table 6.3 reveals that eleven (CST1, CST2, CST3, CST4, CST5, CST7, CST8, CST9, CST10, CST11, CST12) of the twelve items that were intended to measure 'customer satisfaction', four (DMP1, DMP2, DMP3, DMP4) of the nine items that were expected to measure 'decision-making process' and three (CD1, CD2, CD4) of the eight items that were intended to measure 'cognitive dissonance' loaded together onto factor one (1). These items were viewed as a single construct by respondents and are termed 'customer satisfaction'.

Table 6.3 indicates that respondents perceived 'cognitive dissonance' as a single construct. This indicates that four (CD5, CD6, CD7, CD8) of the eight items that are intended to measure 'cognitive dissonance' loaded together onto factor two (2). Table 6.3 further indicates that respondents viewed 'decision-making process' as a single construct. This indicates that four (DMP6, DMP7 DMP8, DMP9) of the nine items that are intended to measure 'decision-making process' loaded together onto factor three (3).

One item (CD3) expected to measure 'cognitive dissonance' cross loaded and was deleted. Two items expected to measure 'decision-making process' (DMP5) and 'customer satisfaction' (CST6) were deleted as they did not load to a significant extent ($p < 0.4$). This indicates that these items did not demonstrate sufficient discriminant validity.

6.3.2 Reliability of the measuring instrument

Reliability refers to the measure of stability or consistency of a measuring instrument when applied on an identical construct repeatedly. In other words, reliability determines how consistently a set of items measures a single construct repeatedly. The internal consistency reliability was employed in determining the reliability of the measuring instrument in this study. In accessing the internal reliability, the Cronbach's alpha was used (Baumgarten, 2013:4).

Specifically, a Cronbach's alpha can assume values between zero and one, and a higher Cronbach's alpha indicates satisfactory reliability. This study assumes that a Cronbach's alpha of 0.6 and above is considered appropriate and good internal consistency reliability (Patil & Bhakkad, 2014:13; Zeanah, 2012:243).

The reliability of the measuring instrument was essential, because it ensured the consistency of the measure, thereby allowing credibility and confidence of a true measure (Godwin, 2009:134). Table 6.4 shows the Cronbach's alpha of the latent variables based on the exploratory factor analysis. Although the results indicated in Table 6.4 show Cronbach's alpha between 0.6 and 0.9, the Cronbach's alpha of 'service encounter experiences' was initially 0.406. In order to improve scale reliability of this variable, two items were deleted (PRER5 and PRER1) and the reliability of 'service encounter experiences' improved to 0.627. This indicates that the measuring instrument has good reliability with Cronbach's alpha greater than 0.60 and above which is regarded as acceptable in this study (Patil & Bhakkad, 2014:13).

Table 6.4 reveals the Cronbach's alpha values of the latent variables based on the exploratory factor analysis.

Table 6.4: Cronbach's alpha values of the latent variables based on the exploratory factor analysis

Latent variables	Individual items	Cronbach's alpha
Personal characteristics (DEM1)	PREB1, PREB2, PREB3, PREB4, PREB5, PREF1, PREF3, PREE4, PREE6, PREE7, PREE10, PREE11, PREG3, PREG4, PREG6, EFP3, EFH5, EFH6, PREO3	0.860
Service encounter experiences (DEM2)	PREA3, PREA5, PREE1, PREE2, PREG2, PREM3, PREM5, PRER1, PRER5	0.627
Accessibility (DEM3)	PREA1, PREA2, PREB7, PREB9, PREB10, PREM1, PREO5	0.700
Personal income (PI)	EFP1, EFP2, EFP4, EFP6, EFH2	0.702
Health insurance membership (HIM)	EFH1, EFH3, EFH4, EFH7, EFH8, PRER2, PRER4	0.703
Support sources (SS)	EFF1, EFF3, EFF4, PREE5, PREE9, PREM 2	0.600
Decision-making process (DMP)	DMP6, DMP7, DMP8, DMP9	0.901
Customer satisfaction (CST)	DMP1, DMP2, DMP3, DMP4, CST1, CST2, CST3, CST4, CST5, CST7, CST8, CST9, CST10, CST11, CST12, CD1, CD2, CD4	0.750
Cognitive dissonance (CD)	CD5, CD6, CD7, CD8	0.614

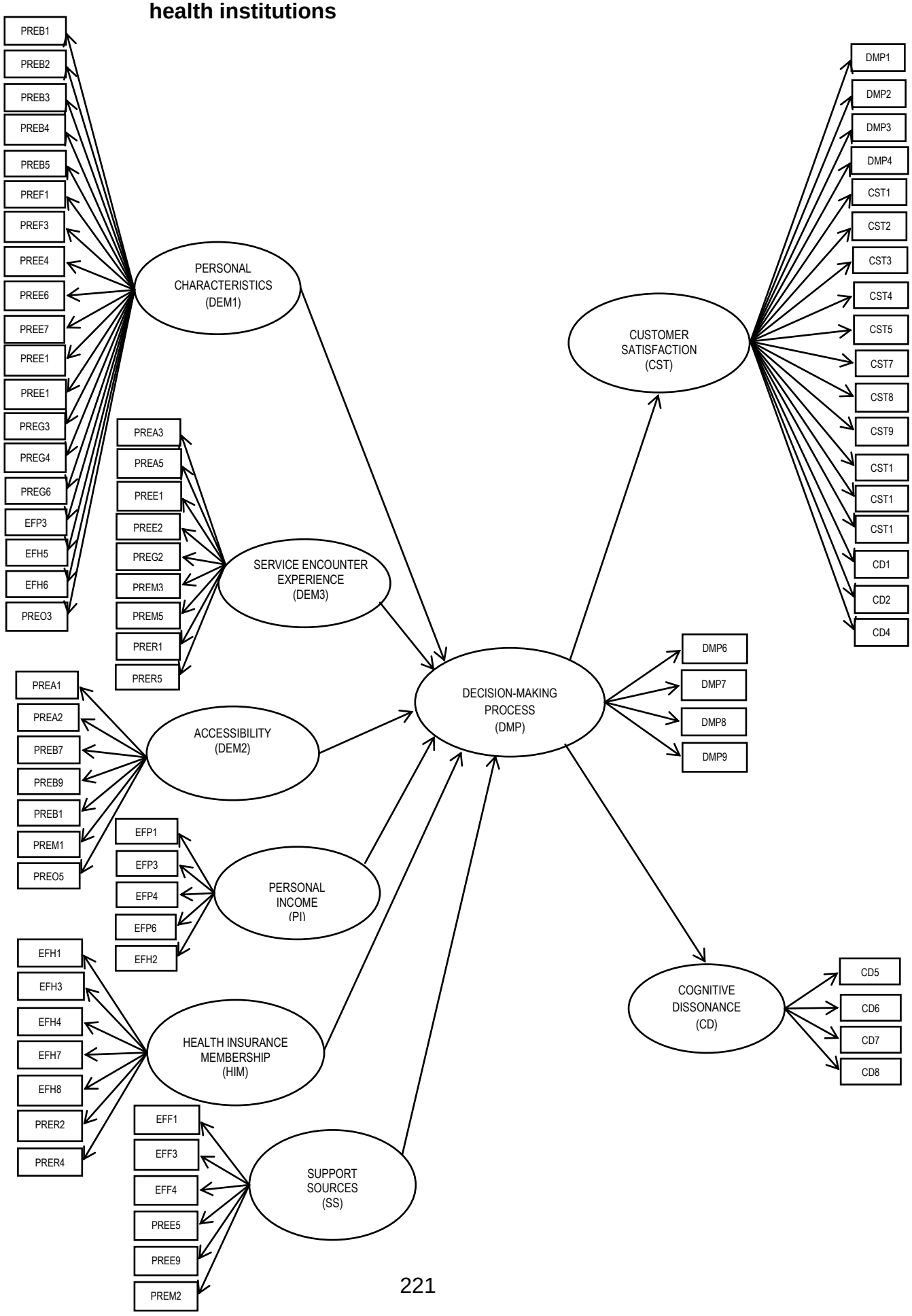
Source: Own construction.

The study retains DEM1, DEM2, DEM3, PI, HIM, SS, DMP, CST and CD since their Cronbach's alpha values were above cut-off point.

Table 6.4 displays the individual items measuring the latent variables. The changes that occurred between items, as a result of the comprehensive exploratory factor analysis (CEFA), resulted in the reformulation of the hypotheses to enable the adaption to the theoretical model of the study. The latent variables and individual items in Table 6.4 are therefore subjected to regression analysis.

Figure 6.2 shows the adapted model of the relationships among variables based on clients' perceptions and outcomes of decision-making process.

Figure 6.2 The adapted model of the relationships among variables based on clients' perceptions of decision-making process in private health institutions



Due to the formulation of new variables, the hypotheses will be changed and adapted to the theoretical model. The hypotheses in Figure 6.3 will be subjected to empirical verification.

H^1: *There is a relationship between demographics and consumer decision-making process in a private health institution.*

H^1 is modified to $H^{1.1}$, $H^{1.2}$ and $H^{1.3}$.

$H^{1.1}$: *There is a relationship between personal characteristics (DEM1) and consumer decision-making process in a private health institution.*

$H^{1.2}$: *There is a relationship between service encounter experiences (DEM2) and consumer decision-making process in a private health institution.*

$H^{1.3}$: *There is a relationship between accessibility (DEM3) and consumer decision-making process in a private health institution.*

H^4: *There is a relationship between personal income and consumer decision-making process in a private health institution.*

H^5: *There is a relationship between access to health insurance and consumer decision-making process in a private health institution.*

H^5 is modified to $H^{5.1}$.

$H^{5.1}$: *There is a relationship between access to health insurance membership and consumer decision-making process in a private health institution.*

H^6: *There is a relationship between family financial support and consumer decision-making process regarding private health institution.*

H^6 is modified to $H^{6.1}$.

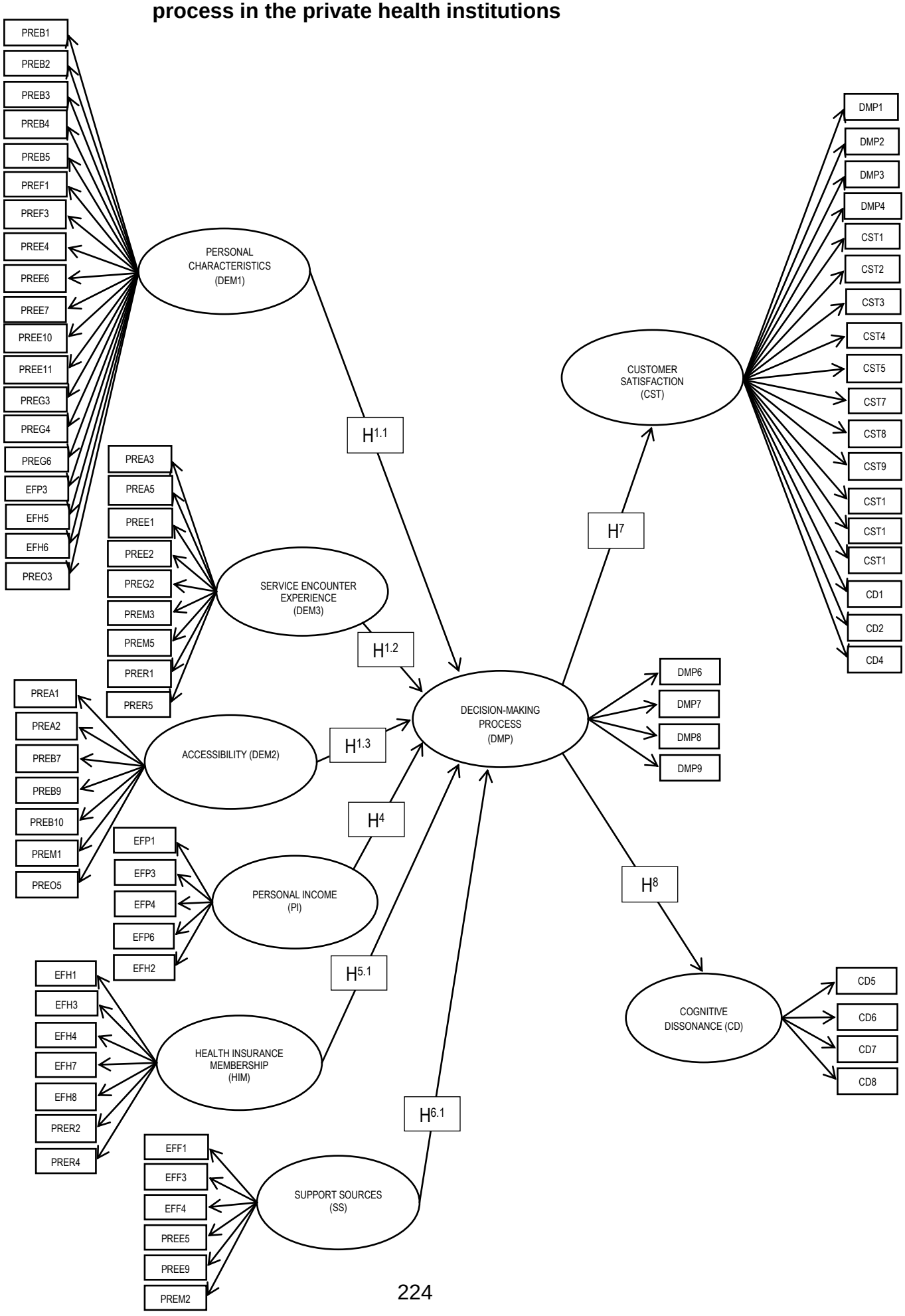
$H^{6.1}$: There is a relationship between support sources and consumer decision-making process regarding private health institution.

H^7: There is a relationship between the consumer decision-making process and customer satisfaction in a private health institution.

H^8: There is a relationship between the consumer decision-making process and cognitive dissonance in a private health institution.

Figure 6.3 shows the hypothesised model of client's perceptions of the decision-making process in the private health institutions.

Figure 6.3: The hypothesised model of client's perceptions of the decision- making process in the private health institutions



6.3.3 Descriptive statistics of independent, dependent and mediating variables

This study used a 5-point Likert scale (strongly disagree-1, disagree-2, indifferent-3, agree-4 and strongly agree-5) to measure the variables in the measuring instrument as identified by the EFA. Table 6.5 shows the means score and the standard deviation values for each of the given variables in the study.

Table 6.5: Descriptive statistics of variables

Variables	Mean	Standard deviation
Personal characteristics (DEM1)	3.20	0.63
Service encounter experiences (DEM2)	3.60	0.62
Accessibility (DEM3)	2.93	0.73
Personal income (PI)	2.97	0.80
Health insurance membership (HIM)	3.32	0.69
Support sources (SS)	2.89	0.65
Customer satisfaction (CST)	3.40	0.67
Cognitive dissonance (CD)	3.20	0.87
Decision-making process (DMP)	3.11	0.78

Source: Own construction.

Table 6.5 reveals that personal characteristics (DEM1) have a mean score of 3.20. This indicates that respondents agree to some extent that their personal characteristics will influence their decision to utilise the private health institution. In other words, women are more likely to access and utilise the private health institution and their educational level or occupation will help them decide on utilising the private health institution. Table 6.5 indicates a mean score of 3.60 for service encounter experiences (DEM2). This indicates that respondents agree that they have an encounter or experience to assist the decision-making process.

Table 6.5 shows that respondents disagreed and were neutral to some extent about accessibility (DEM3) (mean score 2.93). This indicates that respondents desire certain medical services (ambulance, health insurance and shorter waiting time) that will aid accessibility and utilisation of the private health institution. Table 6.5 reveals personal income (PI) as having a mean score of 2.97. This indicates that

respondents are not comfortable with the medical fees of the private health institution. Respondents feel that that if the medical fees are affordable or if their organisation can support them financially, they will decide on utilising the private health institution.

Table 6.5 further shows that respondents agree to some extent that health insurance membership (HIM) (mean score 3.32) is needed to enable them to decide on utilising the private health institutions. This indicates that if the Nigerian government or organisations provide health insurance to citizens and employees, it will enable them to decide on utilising the private health institution. Respondents further feel that there are no sufficient support sources (SS) (mean score 2.89) to enable them in accessing and utilising the private health institution services. In other words, if respondents are supported by their employers to access and utilise the service facility and family members provide financial and emotional support, they will be encouraged to utilise the private health institutions.

Table 6.5 further indicates that respondents were neutral and agreed to some extent about the decision-making process (DMP) (mean score 3.11). Respondents feel that for them to be involved in the decision-making process in utilising the private health institutions, the medical cost must be affordable and there should be shared decision- making between the medical practitioner and respondents about illness and treatment options.

Table 6.5 further shows that customer satisfaction (CST) has a mean score of 3.40. This indicates that respondents were satisfied to some extent with the services of the private health institutions but they desire an improvement. Respondents need the private health institutions to improve the health care services in the areas of responsiveness, professionalism, privacy, ambiance, personal encounter and cleanliness. As can be seen from Table 6.5, cognitive dissonance (CD) has a mean score of 3.20. This indicates that respondents agree, to some extent, that they are likely to make decisions to visit the private health institution again if the overall services delivery is improved.

6.4 REGRESSION ANALYSIS

Regression analysis is a statistical technique that is used in investigating, measuring or estimating the linear relationship (straight line) among variables. In other words, regression analysis investigates the effect of the independent variable on the dependent variable. Regression analysis was carried out in this study because it was useful in reporting the expectation or outcome of changes that occurred in the dependent variable (response variable denoted as *y*) when two or more of the independent variables change (predictor or explanatory variable denoted as *x*) (Chatterjee & Hadi, 2013:1).

The simple linear and multiple regression analysis are the means through which regression analysis can be achieved in a study. In other words, linear regression analysis focuses on investigating the linear relationship between one independent and one dependent variable, whilst multiple regression analysis focuses on measuring and predicting the linear relationship between two or more independent variables on a dependent variable (Lind, Marchal & Wathen, 2008:403-439). The multiple regression analysis was used in this study to measure the linear relationship and predict the unknown value of the response variable (dependent variable) from the known value of two or more predictor variables (independent variables) (Lind *et al*., 2008:439).

This study carried out multiple regression analysis by investigating if the independent variables had a considerable influence on the decision-making process and if the outcomes (customer satisfaction and cognitive dissonance) influence the decision-making process. The results obtained from the multiple regression analysis are presented in Table 6.6, Table 6.7 and Table 6.8.

6.4.1 The clients' perceptions of the decision-making process in the private health institutions

Table 6.6 reveals the influence of demographics, health insurance membership, personal income, accessibility, support sources and service encounter experiences on the clients' decision-making process based on regression analysis. Table 6.7 and Table 6.8 further reveals the influence of the decision-making process on customer satisfaction and cognitive dissonance.

6.4.1.1 The influence of demographics, health insurance membership, personal income, accessibility, support sources and service encounter experiences

Table 6.6 indicates that 'personal income' ($b = 0.304$, $p < 0.001$), 'support sources' ($b = 0.218$, $p < 0.001$) and 'service encounter experiences' ($b = 0.184$, $p < 0.001$) are positively related to decision-making process. Although Table 6.6 reveals that 'accessibility' (DEM3) is positively related to 'decision-making process' (DMP), the relationship has proven to be weak. Table 6.7 reveals that 'DEM3' exerts an influence ($p < 0.10$) on 'DMP'. This indicates that the relationship between them is weak. In total, the R^2 of 0.207 explains the 45% of variability in the model is explained by the mediating variable (decision-making process) as shown in Table 6.6. Table 6.6 further shows that 'personal characteristics' ($r = -0.006$, NS) and 'health insurance membership' ($r = -0.029$, NS) do not exert a significant influence on 'decision-making process'.

Table 6.6: Regression analysis: Influence of demographics, health insurance membership, personal income, accessibility, support sources and service encounter experiences

	REGRESSION SUMMARY FOR DEPENDENT VARIABLE: DECISION-MAKING PROCESS					
Parameter	**Beta b***	**Std. Error**	**b**	**Std Error**	**t-value**	**p-value**
Personal characteristics (DEM1)	-0.006	0.052	-0.007	0.064	-1.119	0.904
Service encounter experiences (DEM2)	**0.146**	**0.047**	**0.184**	**0.060**	**3.116**	**0.001****
Accessibility (DEM3)	0.081	0.048	0.087	0.052	1.685	0.092
Personal income (PI)	**0.314**	0.044	**0.304**	0.043	**7.071**	**0.001*****
Health insurance membership (HIM)	-0.029	0.046	-0.033	0.052	-0.628	0.529
Support sources (SS)	**0.182**	**0.045**	**0.218**	**0.054**	**4.024**	**0.001*****
R **R^2**	**F**		**Std Error of estimate**		**P**	
45% 0.2065152	19.216		0.69812		p < 0.000	
* = p < 0.05 ** = p < 0.01 *** = p < 0.001						

6.4.1.2 The influence of decision-making process on customer satisfaction

Table 6.7 shows that the R^2 of 0.055 indicates that 24% of the variability in the model is explained by the variable customer satisfaction. Furthermore, customer satisfaction (b = 0.203, p < 0.001) has a positive relationship with decision-making process.

Table 6.7: Regression analysis: Influence of decision-making process on customer satisfaction

	REGRESSION SUMMARY FOR DEPENDENT VARIABLE: CUSTOMER SATISFACTION					
Parameter	**Beta b***	**Std. Error**	**b**	**Std Error**	**t-value**	**p-value**
Decision-making process (DMP)	**0.236**	0.046	**0.203**	0.039	**5.14801**	**0.001*****
R **R^2**	**F**		**Std Error of estimate**		**P**	
24% 0.05585222	26.50		0.65024		p < 0 .000	
* = p < 0.05 ** = p < 0.01 *** = p < 0.001						

6.4.1.3 The influence of decision-making process on cognitive dissonance

Table 6.8 shows that the R^2 of 0.029 indicates that 17% of the variability in the model is explained by the variable 'cognitive dissonance'. Cognitive dissonance (b = 0.193, p < 0.001) has a positive relationship with decision-making process.

Table 6.8: Regression analysis: Influence of decision-making process on cognitive dissonance

	REGRESSION SUMMARY FOR DEPENDENT VARIABLE: COGNITIVE DISSONANCE					
Parameter	**Beta b***	**Std. Error**	**b**	**Std Error**	**t-value**	**p-value**
Decision-making process (DMP)	**0.172**	0.047	**0.193**	0.052	**3.70034**	**0.001*** **
R **R^2**	**F**		**Std Error of estimate**		**P**	
17% 0.029657	13.692		0.86169		p < 0 .000	
* = p < 0.05 ** = p < 0.01 *** = p < 0.001						

In this study, the t-values reported in Table 6.6 to Table 6.8 indicate the high to moderate impact of the independent variables on 'decision-making process' and the high impact of the mediating variable on dependent variables. The t-value indicated in Table 6.6 reveals that accessibility has a weak impact on decision-making process with a t-value of t = 1.685. Personal income has a stronger impact on the decision-making process with a highest t-value of t = 7.071 as indicated in Table 6.6.

According to Table 6.6, support sources equally have a strong impact on decision-making process with a t-value of t = 4.024. Table 6.7 indicates a strong impact of decision-making process on customer satisfaction with a high t-value of t = 5.1480. Furthermore, the t-value indicated in Table 6.6 reflects that service encounter experiences has a moderate impact on the decision-making process with a t-value of t = 3.116. Cognitive dissonance has a moderate impact on the decision-making process with a t-value of t = 3.700 as indicated in Table 6.8.

6.5 CORRELATION ANALYSIS

Correlation analysis is useful in determining the direction and strength of the linear relationship that exists between two variables. In other words, correlation analysis indicates that two variables have a strong relationship if the correlation between the two variables is high or strong, whilst a low or weak correlation means that the variables in question are unrelated (Lind *et al*., 2012:463). The correlation coefficient measures the relationship between two variables and it is not influenced by the units of measurement for variables *x* and *y*. The type of correlation coefficient used in this study is the Pearson *r* (linear or Pearson product moment correlation) (Anderson, Sweeney, Williams, Camm & Cochran, 2014:145).

The correlation coefficient can assume values between -1.00 to +1.00. A value of -1.00 indicates that a relationship (perfect negative linear correlation) exists between variable *x* (independent) and variable *y* (dependent), with all data points lying on a line meaning that variable *y* decreases as variable *x* increases. Similarly, values close to 0.00 or 0.00 implies that *x* and *y* are not linearly related or no relationship exists between the two variables in question. Conversely, a value of +1.00 indicates that the relationship that exists between variable *x* and variable *y* is positively related (perfect positive linear correlation), with all data points lying on a line implying that *y* increases when *x* increases (Anderson *et al*., 2014:148).

Table 6.9 provides the result of the correlation analysis between the variables in this study.

Table 6.9: Correlation matrix of variables of the study

Variables	Mean	Std.Dev.	DEM1	HIM	PI	DEM3	SS	DEM2	CST	CD	DMP
Personal characteristics (DEM1)	3.197	0.633	**1.000**	0.270	0.178	0.470	0.263	0.366	0.677	0.207	0.181
Health insurance membership (HIM)	3.321	0.694	0.290	**1.000**	0.173	0.139	0.203	0.316	0.254	0.293	0.118
Personal income (PI)	2.971	0.804	0.178	0.173	**1.000**	0.047	0.258	0.091	0.111	0.196	0.372
Accessibility (DEM3)	2.930	0.727	0.470	0.139	0.047	**1.000**	0.155	0.235	0.399	0.122	0.152
Support sources (SS)	2.893	0.651	0.263	0.202	0.258	0.155	**1.000**	0.115	0.184	0.250	0.286
Service encounter experiences (DEM2)	3.603	0.617	0.366	0.316	0.091	0.235	0.115	**1.000**	0.381	0.131	0.203
Customer satisfaction (CST)	3.399	0.668	0.677	0.254	0.111	0.399	0.184	0.381	**1.000**	0.370	0.236
Cognitive dissonance (CD)	3.203	0.874	0.207	0.293	0.196	0.122	0.250	0.131	0.370	**1.000**	0.172
Decision-making process (DMP)	3.113	0.778	0.181	0.118	0.372	0.152	0.286	0.203	0.236	0.172	**1.000**

Red marked correlations are significant at $p < 0.05000$

The results in Table 6.9 indicate that there is a positive correlation between personal income and decision-making process with a coefficient of 0.372. This indicates that clients can gain entry or make a decision to utilise health care services from the private health institution if there is sufficient personal income that can off-set the medical bills and if their occupation provides them with the financial resources to make purchase.

Furthermore, Table 6.9 indicates that support services are positively related to decision-making process to a coefficient of 0.286. This indicates that clients can make a decision to utilise health care services from the private health institution if there is availability of financial support from family members, if they are covered by their family medical insurance, if medical staff at the private health institution provide them with basic medical support and if the private health institution provides special health care service to clients in certain marital status.

The result in Table 6.9 shows that service encounter experiences are positively related to decision-making process with a coefficient of 0.203. This indicates that service encounter experiences can enable clients to decide on purchasing health care services from the private health institutions. It is evident from Table 6.9 that customer satisfaction has a positive relationship with the decision-making process with a coefficient of 0.236. This indicates that clients will be satisfied if the services received exceed their expectation. Table 6.9 further indicates that cognitive dissonance is positively correlated to the decision-making process with a coefficient of 0.172. However, this implies that clients will be disappointed and unhappy if the services received do not exceed their expectation.

The result in Table 6.9 reveals that personal characteristics with a coefficient of 0.181, accessibility with a coefficient of 0.152 and health insurance membership with a coefficient of 0.118 are not significantly associated with the decision-making process.

6.6 RESULTS OF HYPOTHESISED RELATIONSHIPS

The results on hypothesised relationships between the influence of the independent variables on the decision-making process and the influence of the decision-making process on the dependent variable (outcome) are presented.

6.6.1 Results of the influence of the independent variables on the consumer decision-making process

$H^{1.1:}$ *There is a relationship between personal characteristics (DEM1) and consumer decision-making process in a private health institution*

Table 6.6 reveals that personal characteristics (DEM1) is not significantly related to decision-making process (r = -0.006, NS). Table 6.9 shows that there is no significant correlation between personal characteristics (DEM1) and decision-making process with a correlation of 0.181. Therefore, $H^{1.1}$ is rejected and the null hypothesis is accepted.

$H^{1.2:}$ *There is a relationship between service encounter experiences (DEM2) and consumer decision-making process in a private health institution*

Table 6.6 indicates a significant positive relationship between service encounter experiences (DEM2) and the decision-making process (b = 0.184, p < 0.001). Table 6.9 further indicates a moderate significant positive correlation between service encounter experiences and the decision-making process, with a coefficient of 0.203. Therefore, $H^{1.2}$ is accepted.

$H^{1.3:}$ *There is a relationship between accessibility (DEM3) and consumer decision-making process in a private health institution*

Table 6.6 indicates that accessibility (DEM3) does not exert a significant influence on the decision-making process (r = 0.081, NS). Table 6.9 reveals that there is no

relationship between accessibility and the decision-making process with a correlation coefficient of 0.152. Therefore, $H^{1.3}$ is rejected and the null hypothesis accepted.

$H^{4.1}$: There is a relationship between personal income and consumer decision-making process in a private health institution

Table 6.6 reports that personal income (PI) has a significant influence on the decision-making process ($b = 0.304$, $p < 0.001$). Table 6.9 further reveals that personal income is significantly related to the decision-making process with a correlation coefficient of 0.372. Therefore, $H^{4.1}$ is accepted.

$H^{5.1}$: There is a relationship between access to health insurance membership and consumer decision-making process in a private health institution

Table 6.6 indicates that health insurance membership (HIM) do not exert a significant influence on the decision-making process ($r = -0.029$, NS). Table 6.9 further reveals that no relationship exists between health insurance membership and the decision-making process with a correlation of 0.118. Therefore, $H^{5.1}$ is rejected and the null hypothesis accepted.

$H^{6.1}$: There is a relationship between support sources and consumer decision-making process regarding private health institution

Table 6.6 reports a positive relationship between support sources (SS) and the decision-making process ($b = 0.218$, $p < 0.001$). Table 6.9 indicates that there is a significant positive relationship between support sources and the decision-making process with a correlation coefficient of 0.29. Therefore, $H^{6.1}$ is accepted.

6.6.2 Results of the influence of the decision-making process on the outcomes

H^7: There is a relationship between the consumer decision-making process and customer satisfaction in a private health institution

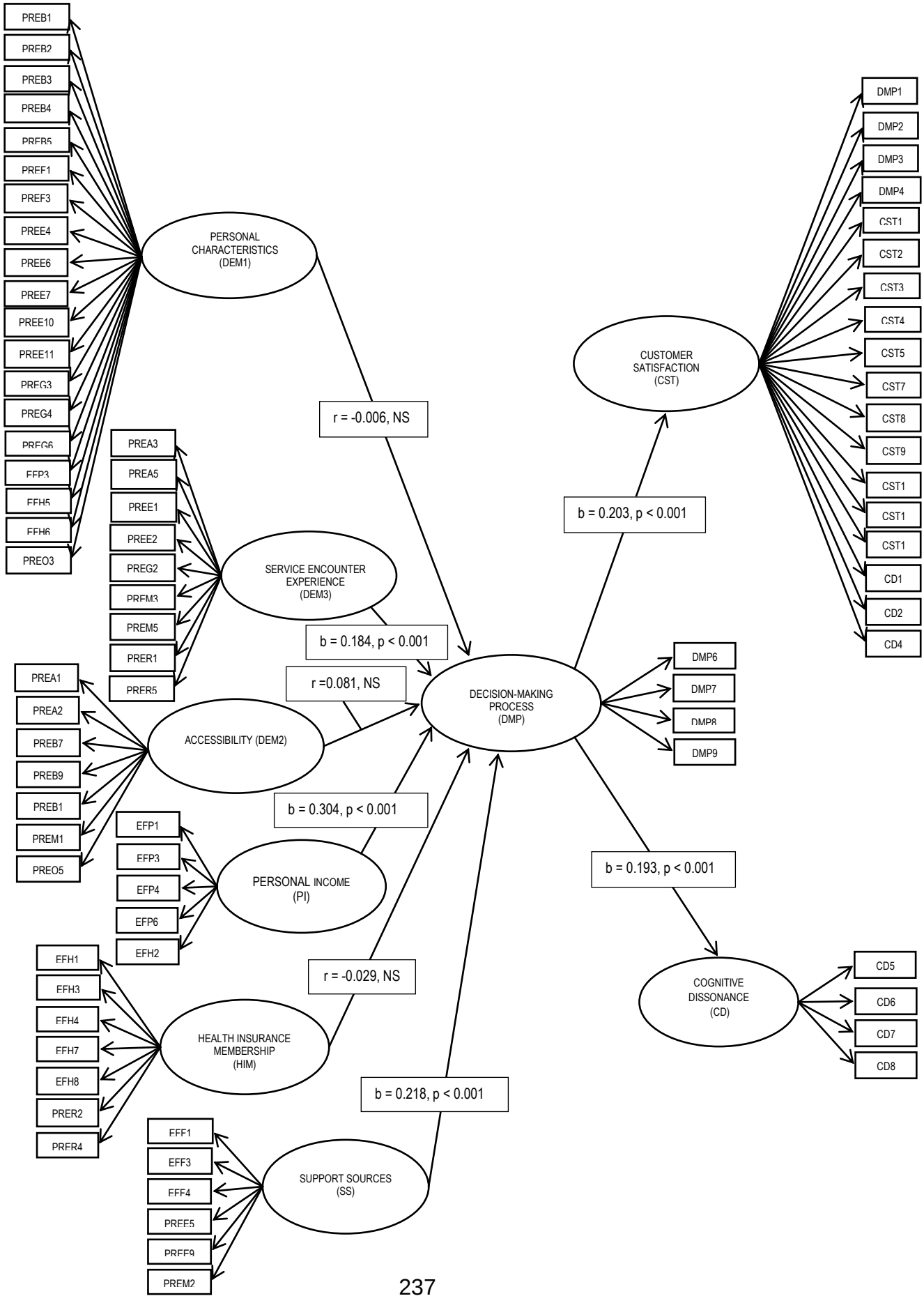
Table 6.7 indicates that customer satisfaction (CST) has a positive relationship with the decision-making process ($b = 0.203$, $p < 0.001$). Table 6.9 further shows that there is a significant positive correlation between customer satisfaction and decision-making process with a correlation coefficient of 0.236. Therefore, H^7 is accepted.

H^8: There is a relationship between the consumer decision-making process and cognitive dissonance in a private health institution

Table 6.8 indicates that cognitive dissonance (CD) has a positive relationship with the decision-making process ($b = 0.193$, $p < 0.001$). Table 6.9 shows that there is a positive correlation between cognitive dissonance and the decision-making process with a coefficient of 0.172. Therefore, H^8 is accepted.

The regression analysis result are summarised in Figure 6.4.

Figure 6.4: Summary of the regression analysis results



6.7 SUMMARY

This chapter presented and discussed the empirical results of the clients' decision-making process regarding private health institutions. The research hypotheses and objectives of the study were presented. The primary data was analysed using the software, Statistica (Version 12). The data analysis was performed in five stages, namely, exploratory factor analysis (EFA), reliability (Cronbach's alpha), descriptive statistics, multiple regression analysis and correlation analysis.

This chapter provides discussions on the perceptions of clients regarding the predisposing and enabling factors. Furthermore, discussions on the perceptions of clients towards the decision-making process and outcomes of decision-making process were presented. This chapter further presented the latent variables that were created on the basis of the exploratory factor analysis. The Cronbach's alpha and individual items associated with each latent variable were presented.

This chapter presents an adapted and hypothesised model of the clients' perceptions of the decision-making process in the private health institutions based on EFA. Results of the hypothesised relationships indicate that service encounter experiences (DEM2), personal income (PI) and support sources (SS) are positively related to the decision-making process, whilst personal characteristics (DEM1), accessibility (DEM3) and health insurance membership (HIM) do not exert a significant influence on the decision-making process. This chapter presents a model on the summary of the regression analysis results.

The following chapter will examine the results obtained from the analysis and will provide a summary, recommendation that are based on the findings and conclusion of the study.

CHAPTER 7
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The previous chapter provided the empirical results and discussion of the factors which influence the consumer decision-making process at the private health institutions. The results and discussions regarding the influence of the decision-making process on customer satisfaction and cognitive dissonance were also provided. Therefore, chapter seven will focus on achieving research questions and primary objectives presented in chapter one. This chapter also provides a summary of preceding chapters, a conclusion and recommendations which are based on the empirical results reported in chapter six and the implications as well as limitations of the study.

7.2 SUMMARY OF THE LITERATURE CHAPTERS

Chapter one provided detailed information about the scope and background to the study. The chapter also discussed the problem statement and introduced the theoretical model of the study. The objectives (primary and secondary), research questions and hypotheses were highlighted and discussed. Furthermore, a brief literature review was presented to introduce the topic of discourse. The chapter concluded with definitions of the concepts used in this study for clarity purpose.

Chapter two presented a comprehensive literature on the overview of the consumer decision-making in general and in the health care sector. This chapter provided an extensive discussion on the stages of the consumer decision-making process (purchase of goods) and the buying process for services (purchase of services). Chapter two provided literature on the types of purchase decisions that clients get involved in, when they need to make a new or repeat purchase. Comprehensive literature was provided on service quality, consumer involvement and decision-making in the health care sector.

Chapter three of this study dealt with the health care sector in general and in Nigeria. An overview of the health care sector in Nigeria was provided. This chapter provided comprehensive discussions of the structure of the health care sector in Nigeria, including the public and private health care. The regulatory bodies and providers of health care services in the public and private health care sector of Nigeria were outlined in detail. This chapter further examined the challenges of the Nigerian health care sector as well as reformation of the Nigerian health care sector. Chapter three provided a comparison and assessment of the health system of Nigeria and that of France. This chapter concluded with strategies for an effective health system.

Chapter four presented a model for consumer decision-making process of private health institutions. The model highlighted the independent variables (predisposing and enabling factors), mediating variable (decision-making process) and dependent variables (customer satisfaction and cognitive dissonance). Chapter four provided literature on the variables of the study and it presented literature that supports the hypotheses that were formulated to achieve the objectives of this study. On the basis of literature review on the variables, it was hypothesised that there is a relationship between decision-making process and the different variables of predisposing factors, namely, demographics (H^1); social structure (H^2); beliefs (H^3) as well as enabling factors, namely, personal income (H^4); health insurance (H^5); family financial support (H^6) and dependent variables, namely, customer satisfaction (H^7) and cognitive dissonance (H^8).

Chapter five of this study discussed extensively the research design, paradigm and methodology of this research study. This chapter highlighted several methods of conducting a research (qualitative, quantitative and mixed methods). Sampling and the steps in the sampling design process were presented. The design and structure of the research instrument and the reliability and validity of the measuring instrument was discussed. Chapter five provided literature on the data collection methods and means by which the data will be analysed. Furthermore, the chapter provided discussions of the methods (EFA, reliability of the measuring instrument, descriptive statistics, regression analysis and correlation analysis) selected to analyse the primary data using statistical software (Statistica package, version 12).

Chapter six provided the empirical evaluation and results of the clients' decision-making process regarding private health institutions. This chapter presented results from the methods which were used to analyse the data. The results from the EFA, reliability, descriptive statistics, regression analysis and correlation analysis were presented and discussed. The hypotheses of this study were reformulated on the basis of the EFA results, and new variables were created. The hypotheses formulated were examined on the strength of the empirical results. This chapter provided the results on the acceptance/rejection of the hypotheses.

7.3 CONCLUSIONS ON RESEARCH PROBLEMS AND QUESTIONS OF THE STUDY

The secondary data (literature review) and evaluation of the empirical results provided results that were used to examine the problem statements and research questions highlighted in this study.

7.3.1 First research problem

The first research problem is formulated as follows:

Expanding the current understanding of the influencing factors of the decision-making process regarding the utilisation of private health institutions in Nigeria

This study provides extensive literature on the factors that influence the clients' decision-making process regarding the utilisation of the private health institutions in Nigeria. Empirical information was provided on two influencing factors namely, predisposing and enabling factors. The predisposing and enabling factors were made up of variables that were considered to influence the clients' decision-making process. Chapter four of the study provides comprehensive literature concerning the relationship between the decision-making process and the variables of the predisposing and enabling factors, such as demographics, social structure, beliefs, personal income, health insurance and family financial support. Through this extensive literature, the study provided a better understanding of the influencing factors (predisposing and enabling) and their impact on the decision-making

process. The discussion in chapter four reveals that clients are constrained by these factors and it influences their decision-making process to access and utilise private health institutions. Lo and Fulda (2008:2) support this view.

Additionally, the study provides literature on the decision-making process and buying process for services. Specifically, chapter two dealt with the various stages that consumers (product buying) and clients (service buying) will go through when they need to make a purchase decision. Chapter two identified models and provided a detailed discussion to understand the stages of the decision-making process and buying process for services. Therefore, various types of purchase decisions (new or repeat) were differentiated and discussed. Armstrong and Kotler, (2005:160), Boshoff and Du Plessiss (2009:63) and McDaniel *et al*. (2006:199) support this notion.

Further, since this study focused on health care services decisions, effort was made to discuss and evaluate service quality and its importance during the decision-making process. The discussion of how clients will evaluate and make decisions to purchase services was provided. The benefits and challenges of decision-making process were provided to understand the significance of client satisfaction.

The empirical results of this study expanded the understanding of factors that will influence the clients' decision-making process. The empirical results shows that service encounter experience, personal income and support sources will influence clients' decision-making process regarding the utilisation of private health institutions in Nigeria. Devaux and De Looper (2012:17), Diaz *et al*. (2013:195) and Palmer (2005:68) support this view.

7.3.2 Second research problem

The second research problem is the following:

The need to understand clients' satisfaction and cognitive dissonance regarding the utilisation of private health institutions in Nigeria

This study provides the discussion of the influence of the decision-making process on customer satisfaction and cognitive dissonance. The literature review in chapter four revealed that clients will be satisfied when the overall health care services delivery provided by the private health institution exceeds or matches clients' expectation. Clients will experience cognitive dissonance when they doubt or feel disappointed with the health care services received (Joubert, 2010:139).

This study provides empirical research that supports the findings that clients' satisfaction and cognitive dissonance will influence clients' decision-making process regarding the utilisation of private health institutions in Nigeria. Ha (2006:137) confirms this view. Empirical research indicates that clients are likely to repeat health care service purchases from the private health institutions if the services are improved. This indicates that clients will be satisfied with making decisions to utilise the private health institutions but improvement in the overall services in areas such as, effective communication between clients and medical personnel, enhanced ambiance of medical facility, shorter waiting time and the visible privacy of clients achieve higher level of customer satisfaction. This situation is affirmed in literature where researchers indicate that clients will be satisfied when the private health institutions create what the clients' value to improve their service delivery to the clients. Flint *et al*. (2011:222) support this notion.

Empirical research further indicates that clients are likely to experience cognitive dissonance if private health institutions do not provide health care services that meet or exceeds clients' expectation. Bose and Sarker (2012:192) agree that improving customer satisfaction and addressing cognitive dissonance in delivering health care services is important so as to create a positive brand image, better satisfy the needs of clients, attract and retain new clients.

7.3.3 Third research problem

The third research problem to be addressed is the following:

The need to create strategies that will help clients to cope with financial constraints in the payment of medical fees in the private health institutions

This study provides literature of the enabling factors, such as, personal income, health insurance and financial family support. This study provides the discussion which revealed that enabling factors can grant clients access to and the utilisation of the private health institutions in Nigeria. Empirical research shows that financial assistance from family members and medical insurance membership are possible strategies that will help clients manage their bills in the private health institutions in Nigeria. Babitsch *et al*. (2012:3), McIntyre (2012:489) and Scheppers *et al*. (2006:340-341) support this notion.

The empirical research revealed that the cost of medical fees of the private health institutions in Nigeria is high and can only be afforded by clients with the enabling means (personal income, financial support from family members and health insurance). However, empirical research revealed that clients are not comfortable with the high cost of medical fees of the private health institutions. Therefore, this chapter will provide possible strategies that will assist clients to manage their medical bills of private health institutions.

7.3.4 Answers to the research questions of this study

The five research questions and the results based on the literature are summarised in Table 7.1.

Table 7.1: Summary of answers to the research questions of this study

RQ1: How does demographic impact on clients' decision-making process in private health institution?
Research results: The health seeking behaviour of clients is influenced by their age which is the decision that influences the client to access and utilise private health institutions. In other words, purchase decisions regarding the utilisation of health care services is more for the elderly than it is for the younger clientele. The elderly are likely to have a greater need than younger clients for health care services in the private health institution as a result of their failing health. Liu *et al*. (2012:253) and Rechel, Doyle, Grundy and McKee (2009:5-7) support this view. Prior research maintains that the decision to utilise health care services is influenced by gender. Male figures are likely to make decisions regarding the utilisation of private health institutions because of their authority as the head of the household or their income level. Women are more inclined to access and utilise more health care services from the private health institutions to resolve their need for child birth and gynecological issues. Redondo-Sendino *et al*. (2006:155) and Singh *et al*. (2011:5) support this notion. The need to access and utilise health care services arises as clients pass through stages in their marital status. This indicates that the need to access and utilise the private health institutions is different for the single, married, widowed and divorced. Prior research indicates that clients that are single are likely to purchase less health care services than married clients with children. Clients that are married without children will purchase less health care services than married clients with children. The widowed clients are more likely to visit the private health institutions due to conditions arising from the death of their spouse. Various researchers support this view (Iwashyna *&* Chritakis, 2003:21; Manzoor *et al*., 2009:101).
RQ2: How do social structure and beliefs impact on the clients' decision-making process in a private health institution?
Research results: Numerous researchers indicate that clients that are educated are considered to have more knowledge and greater awareness of the benefits and importance of the access and utilisation of health care services from the private health

institution. However, clients that are uneducated may decline to utilise private health institutions and resort to the utilisation of the chemist or traditional medicine for the treatment of their ailments. Clients' awareness of diseases and medication influence them to purchase and utilise the private health institutions. Alguwaihes and Shah (2009:26) support this view.

Prior research further indicates that the occupation of clients can help in differentiating them from the level of income that is earned. In other words, a client's occupation determines the level of income that the client earned. The income, for example, earned by a white collar professional is likely to be higher than that of a manual labourer. This income earned as a result of the occupation determines the type and quality of the health care services that clients can afford to receive. White collar professionals, for example, may purchase health care services from the private health institutions because they can afford it, whilst manual labourers are likely to utilise the public health institutions because it is cheaper. Halleröd and Gustafsson (2010:117) support this notion. Family size (number of people that resides in the household) influences the decision- making of clients regarding the utilisation of health care services from the private health institution. A larger family size of eight are likely to have more need to purchase and utilise health care services whilst a smaller family size of three will have less need for health care services regarding utilisation of the private health institutions. This notion is shared by Chakraborty *et al*. (2003:328).

Benjamins and Brown (2004:110) found that clients that are religiously active are likely to decline the need to make purchase decisions regarding the utilisation of health care services from the private health institutions. Instead, religious clients that decline the purchase of health care services, are likely to seek wellness by performing religious practises, such as, prayers, meditation, constant use of religious materials and media. This situation influences the clients' decision-making towards utilisation of health care services from the private health institutions. This study identified various beliefs that impact on clients' decision-making process regarding the utilisation of services offered at a private health institution. Beliefs relating to religion, use of traditional medicines, culture, personal beliefs (perspectives), attitudes and values were considered to influence where clients seek wellness.

RQ3: How do personal income and health insurance impact on the clients' decision-making process in a private health institution?

Research results: This study reveals that access and utilisation of health care services in

the private health institutions can be granted to clients on the basis of their ability to pay bills from their personal income. This study indicates that clients with lower income or insufficient income are likely not to have access and not to make decisions to utilise the private health institutions. Moreover, clients with high income can enjoy access and make decisions to utilise the private health institutions. Fakuda and Hiyoshi (2012:304) support this notion.

Health insurance is an alternative means that can facilitate the access to and utilisation of health care services in the private health institution. The availability of a medical insurance coverage protects clients from financial constraints associated with the utilisation of private health institutions. Clients with medical insurance are likely to make decisions to access and utilise the private health institutions, whilst clients that are not covered by health insurance are likely not to have access to the private health institution. Mullner (2009:325) supports this view.

RQ4: What is the impact of family financial support on the clients' decision-making process?

Research results: Family financial support is a means by which clients can access and utilise the private health institutions. When there is an absence of personal income and medical insurance coverage, family members can pool financial resources to support or pay for the medical fees of a client. Therefore, financial support from family members can enable clients to have access to and utilising of the private health institutions. Scheppers *et al*. (2006:326) support this notion.

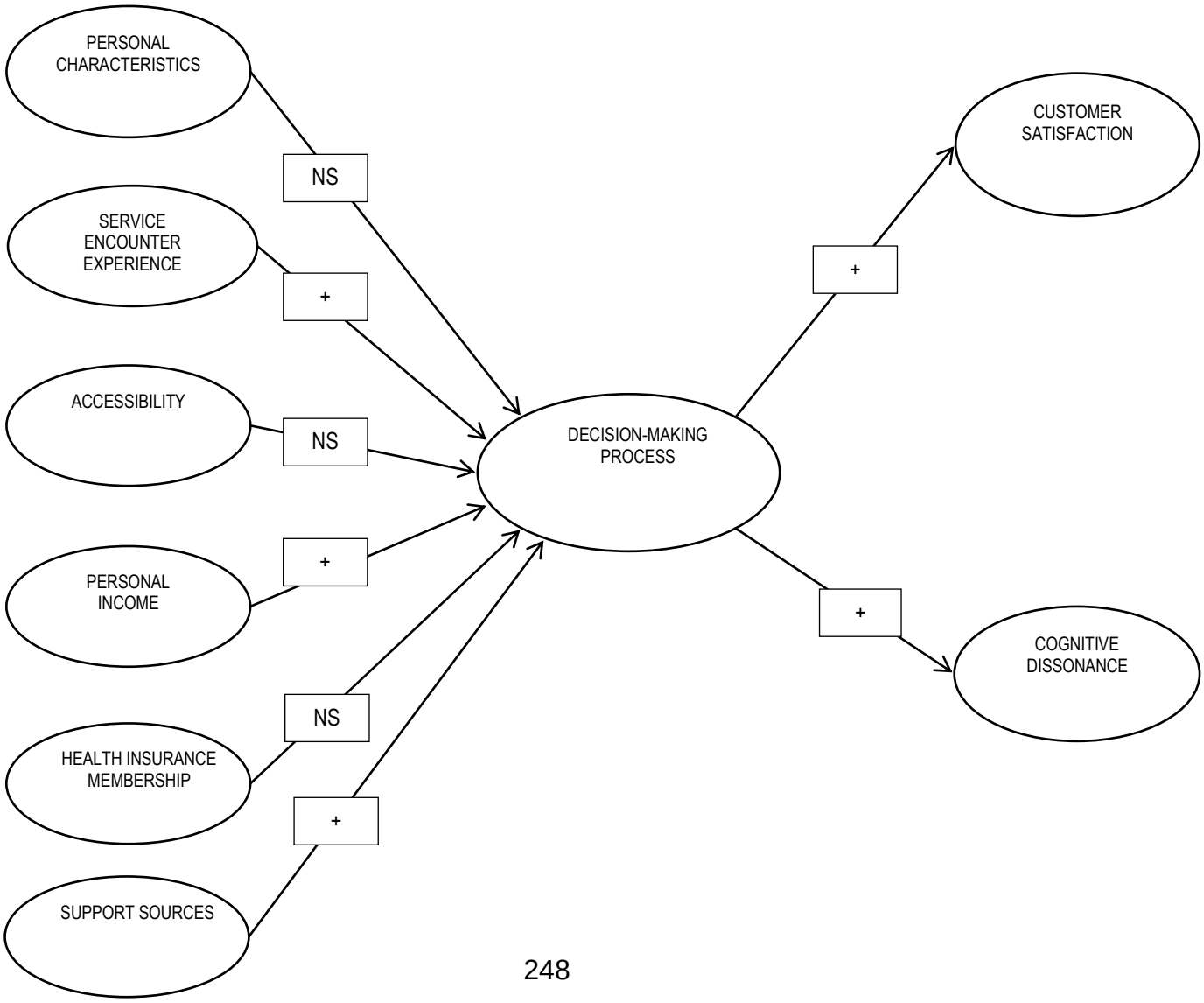
RQ5: What is the impact of decision-making process on customer satisfaction and cognitive dissonance?

Research results: Satisfaction and cognitive dissonance are important factors that marketers consider in retaining existing and attracting new clients. The overall quality and performance of health care services that exceeds the expectations of clients can impact on the clients' decision-making process. This indicates that when clients are satisfied with the overall performances of the private health institution, they are likely to make repeat purchase or recommend services to other clients. Mosahab *et al*. (2010:209) support this view. Clients will experience cognitive dissonance when they doubt and are disappointed with the quality of health care services purchased from the private health institutions. This can create a situation in which clients spread negative word-of-mouth and decline decisions made about a repeat purchase of health care services from the same private health institution. Haksever and Render (2013:47) support this view.

7.4 EMPIRICAL RESULTS AND MANAGERIAL IMPLICATIONS OF THE STUDY

Figure 7.1 graphically summarises the empirical evaluation of the influences and outcomes of the decision-making process regarding private health institutions in chapter six. Figure 7.1 indicates that service encounter experience, personal income and support sources are significantly positively related to the decision-making process, whilst personal characteristics, accessibility and health insurance membership are not significantly related to the decision-making process. The decision-making process also has significant positive relationship with both customer satisfaction and cognitive dissonance.

Figure 7.1: Empirical evaluation of the proposed influences and outcomes of the decision-making process regarding utilisation of private health institutions in Nigeria



7.4.1 The empirical results and implications based on clients' perceptions of service encounter experience on the decision-making process

Due to the intangibility of services, clients find it difficult to judge the service quality before purchase. Therefore, clients try to have contact with the private health institutions to gain service encounter experience that will assist in the evaluation of the quality of the overall services of the private health institutions.

Service encounter experience refers to the manner in which clients search and evaluate the quality of the health care services through physical evidence in the service environment (Palmer, 2005:68). According to Lovelock and Wirtz (2004:286), clients get in contact with the health care providers and physical environment to search and experience quality from the physical environment, professionalism of medical practitioners, the state of the equipment, interior and exterior of the building, ambiance of the facility, respect and support of the client, privacy of clients, empathy towards clients and friendliness of staff.

The empirical investigations indicate that there is a significant positive relationship between demographics and social structure related to service encounter experience and decision-making process. The empirical results reveal that clients believe that they can gain quick access into the private health institutions when their children are experiencing health problems. The results of this study further indicate that clients believe that the private health institutions provide quality care for all different ages. The empirical results further indicate that clients believe that the health care providers at the private health institutions are always professional and calm when dealing with their stressful situation.

The study further reveals that, clients believe that medical care staff communicates with them effectively and they always explain medical terms and diagnosis clearly. Reiling *et al*. (2008:168-180) support this view. The empirical findings reveal that clients believe that explaining their experiences regarding illnesses to the medical practitioners in the private health institutions is acceptable, irrespective of their gender (Reiling *et al*., 2008:168-180).

7.4.2 The empirical results and implications based on clients' perceptions of personal income and the decision-making process

Personal income refers to clients' personal funds that is earned through labour or savings and that is available for the payment for medical fees. Access and utilisation of health care services in the private health institution is granted upon the availability of clients' personal income to offset the medical expenses (Abreu & Greenstein, 2011:301).

The empirical results of this study indicate that there is a significant positive relationship between personal income and the decision-making process. The empirical results indicate that clients believe that their income is sufficient to pay the medical fees for routine or prolonged chronic medication from the private health institutions. The results further indicate that clients believe that their income is sufficient to pay their family's medical fees in the private health institutions. The empirical results also indicate that clients believe that they utilise the services of the private health institutions because it is affordable. The empirical results indicate that clients believe that their job provides medical insurance that enables them to have access to the private health institutions. Swartz (2009:69) supports that the availability of personal income will increase access and utilisation of health care services in the private health institutions.

7.4.3 The empirical results and implications based on clients' perceptions of support sources and the decision-making process

Support sources refer to health related or non-health related assistance that clients require to effectively access and utilise health care services in the private health institutions. In other words, support sources refers to financial (cash), emotional (support to alleviate fear and anxiety), informational (health education, effective communication and advise) and physical assistance (transportation, medicine, ambulance and user friendly facility) from family members and private health institutions that promote access and utilisation of the private health institutions (Bakeera *et al*., 2009:2; Saha, Beach & Cooper, 2008:1277).

The empirical results in this study indicate that there is a significant positive relationship between family financial support, education and demographics related to support sources and the decision-making process. This research indicates that the clients believe financial support from their family members can enable them to utilise the private health institutions. The empirical results further indicate that clients believe that in the event of financial crisis, several family members help them with the payment of medical expenses for a medical emergency in the private health institutions. The results of the study reveal that clients believe they can visit the private health institutions, because they are covered by their family's medical insurance. Diaz *et al*. (2013:195) state that assistance from family members can encourage access to and utilisation of health care services from the private health institutions.

The empirical results reveal that clients believe that the availability of an interpreter at the private health institutions ensured that they understand the medical treatment and instructions. Furthermore, the empirical results indicate that clients believe that the medical staff at the private health institutions ensured that they are familiar with the use of medical technology. Clients also believe that their marital status determines the extent of health care services that can be offered to them by the private health institutions. Saha *et al*. (2008:1281-1283) support this findings.

7.4.4 The empirical results and implications based on clients' perceptions of the decision-making process and customer satisfaction

Customer satisfaction refers to the clients' feeling of happiness or contentment regarding the quality of health care services received from the private health institutions. In other words, when the overall service performance of the private health institutions exceeds a clients' expectation, the clients will be satisfied (Strydom *et al*., 2011:59).

The empirical results indicate that there is a significant positive relationship between the decision-making process and customer satisfaction. The empirical results in this study indicate that clients are satisfied with the location, appearance and functionality of the private health institutions. The empirical results reveal that clients

are satisfied to make a decision to use the private health institutions because they are familiar with it and whenever they get ill unexpectedly.

The empirical results further indicate that clients are satisfied with how the medical staff in the private health institutions pays attention to their medical concerns and how they provide them with feedback regarding their illness. Furthermore, the empirical results indicate that clients are satisfied with the responsiveness, professionalism, degree of knowledge, excellent competency, kindness and respect shown by the medical staff in the private health institutions (Murti, Deshpande & Srivastava, 2013:35).

The empirical results also indicate that clients are satisfied with the effort of the medical staff at the private health institutions in ensuring that they understand how to take medication. Furthermore, the empirical results reveal that clients are satisfied with the privacy that the private health institutions facility provide them, how overcrowding of consultation rooms is managed, odour and ambiance of the private health institutions facility that is free of excessive noise. The results of this study indicate that clients are satisfied with the good quality treatment and medication that is received in the private health institutions. Murti *et al*. (2013:35) support this view. Numerous researchers' support that customer satisfaction in the private health institutions is essential because it encourages clients' repurchase decision-making (Lovelock & Wirtz, 2004:45).

7.4.5 The empirical results and implications based on clients' perceptions of the decision-making process and cognitive dissonance

Cognitive dissonance in this study refers to anxiety, remorse, discomfort, doubt, disappointment or unhappiness that is experienced by clients regarding the utilisation of health care services from the private health institutions (Strydom *et al*., 2011:59). The empirical results in this study reveal that there is a significant positive relationship between the decision-making process and cognitive dissonance.

The empirical results reports that clients believe that they will revisit the private health institutions if the health care service received from the private health

institutions is money well spent. The empirical results further indicate that clients believe that they will revisit the private health institutions because of the prestige it provides them, the attractiveness of the outer appearance and interior décor. Bose and Sarker (2012:219) support that cognitive dissonance should be recognised and reduced in order to retain existing clients and avoid the spread of negative word-of-mouth.

7.5 RECOMMENDATION FOR IMPROVED ACCESS AND UTILISATION OF HEALTH CARE SERVICES IN THE PRIVATE HEALTH INSTITUTIONS

The recommendation for improved access and utilisation of health care services in the private health institutions are the following:

7.5.1 Service encounter experience

During service encounter experience, clients interact directly with the service environment and health care providers of the private health institutions to perceive and evaluate the quality of service they intend to purchase. The private health institutions should be aware that clients gather information from what they observe in the service environment to evaluate the quality of services they intend to purchase. Clients, for example, are likely to perceive low quality of health care services of a private health institution with a dilapidated building located in a filthy neighbourhood and they are likely to perceive high quality of a private health institution with a well-constructed building located in a clean location (Smith, Brugha & Zwi, 2001:15).

Private health institutions should also be aware that clients are likely to pay more when they encounter and experience service quality in the overall health services. Therefore, to create a positive service encounter experience in private health institutions, it is recommended that private health institutions provide and enhance service quality in areas that will appeal to clients during first contact with the service environment (Joint Commission Resources (JCR), 2003:86). JCR (2003:86-87) and Lovelock and Wirtz (2004:292) support that private health institutions should focus on providing and enhancing a number of areas in the service environment.

Services environment (interior and exterior): The services environment of the private health institution is the first contact that clients will have with the private health institution. The outer environment of the service facility should have a well designed building entrance that facilitates easy access for clients and their children in the event of sickness. In other words, the private health institution facility should be user friendly and support easy access for children in the event of sickness. Frontline staff of the private health institutions should be adequate to provide quick service to enable clients to gain easy access for their children during illness. WHO (2010:2) is convinced that children mortality and morbidity will be reduced if private health institutions grant easy access for children in the event of sickness. Therefore, the management of adequate staff and user friendly facility for children promotes access and utilisation and can improve children health outcomes, healthy growth and development.

Service facility should be painted in proper colours and the signage should be properly displayed and should not offensive. The service environment should be neat and quiet to speed up the healing process for children and clients of all the different stages. The private health institution should provide more environmental friendly and peaceful surroundings for children and clients of all ages. There should also be ample parking facilities to accommodate visitors.

The interior décor and colour of the private health institution should be neat and appealing. Furthermore, there should be nice scent, moderate temperature, proper lighting and efficient ventilation for children and clients all of ages. The furniture should be in good condition and be comfortable. Artifacts, posters and photos that are not offensive to culture, religion or race should be used to create a homely ambiance for children and clients of all ages. Furthermore, private health institutions should operate in a user friendly facility free of excessive noise. Consultation and quality treatment should support privacy and the homelike environment needs accommodate visitors and restrooms should be maintained and serviced properly.

Services personnel (services providers and employees): The second service encounter for clients at the private health institutions is the services providers and employees. The services personnel (front line) are responsible for interacting directly

with clients and the first impression clients observe can either thrill or offend clients. Therefore, private health institutions should ensure that their frontline staff as well as the health care providers are easily accessible and have a pleasant personality trait and display good attitudes. Front line staff and health care providers should be friendly, professional, calm, show empathy and respect, patience, willingness to smile and articulate when they attend to clients' enquiry without fuss.

Private health institutions should ensure that their staff is professional and calm when dealing with clients' stressful situations and they should explain medical terms regarding diagnosis so that clients are able to understand. Private health institutions should ensure that they provide improved quality health care services for all ages of clients. Muula, Misiri, Chimalizeni, Mpando, Phiri and Nyaka (2004:182) support that knowledgeable and educated medical staff in the private health institutions are crucial for delivering improved health care services to clients. Thus, improved quality health care services delivered by knowledgeable and educated medical staff will help avoid medical errors and create better health outcomes for clients.

Private health institutions should also ensure that health care providers of both gender are adequate, available and accessible to attend to the health needs and illness of clients. Numerous clients, as a result of religion and culture, may have preference for medical staff of the same gender or a particular gender. Padela, Schneider, He, Ali and Richardson (2010:468) and Victoor, Delnoij, Friele and Rademakers (2012:272) support that availability of medical staff of both gender in the private health institutions will increase client satisfaction, increase client adherence to treatment, increase partnership between staff and clients, reduce waiting times, protect and promote clients' choice and increase clients' utilisation.

Private health institutions should also encourage clients (with or without the presence of spouse) to speak about their illness and to participate in decision-making sharing regarding treatment options and commencement of treatment for a life threatening condition. Private health institutions should know that this strategy will improve interpersonal relationship and effective communication between healthcare providers and clients of both gender and marital status. Effective communication between medical staff and client in the sharing of illness and decision

made on treatment options can enable clients prepare for illness, treatment and consequences associated with treatment. Elwyn *et al*. (2012:1362) support this notion.

Tangibles (materials and medical equipment): Clients also search for quality signals from tangibles as soon as they perceive quality from the interior and exterior of the services environment and services personnel. Private health institutions should ensure that the medical equipment used during treatment is in proper working order to increase the quality of services offered to children and clients of ages. The private health institutions should provide communication materials, such as brochures, that convey friendliness and improved well-being. Private health institutions should provide quality entertainment while clients (children and adults) are waiting, by providing children toys, reading material, soft music or television programmes on improved health outcomes.

7.5.2 Personal income

Personal income is an essential resource that can grant clients access into private health institutions. Private health institutions should be aware that a client's personal income can influence their decision-making to utilise health care services. Private health institutions should seek ways that can encourage access and utilisation of their services. Failure to seek strategies in tackling the influence of personal income and utilisation of health care services, can result in clients utilising the public health institutions, traditional practitioners and chemists for their health needs. In order to address this issue, it is recommended that the private health institutions consider a number of issues.

Reducing administrative cost: The clients' insufficient personal income can discourage them from utilising the private health institutions. Private health institutions can encourage utilisation by reducing administrative cost and thus lower cost and prices of health care services. Administrative costs refer to operational expenses used in operating the business and it is directly related to the production of services. Administrative cost, such as, sales and marketing, communications, rent, utilities, salaries, cost of labour should be reduced. Private health institutions should

adopt the use of information technology such as electronic medical records, electronic transaction and online services which can eliminate the cost associated with sales and marketing, communications and cost of labour. Reducing administrative cost can enable private health institutions to provide quality health care services at an affordable price. Thus, clients' personal income will be sufficient to pay for the medical expenses of family and themselves for routine and prolonged chronic medication in the private health institutions. Wikler and Basch (2012:1876) support this view.

Financial interventions: Clients believe that their personal income has to be sufficient to pay for family medical expenses as well as for prolonged chronic medication for themselves. Financial intervention through community support, health care vouchers and health equity funds are strategies that can address the issue of insufficient personal income, cost of services and affordability. Financial interventions can come through community health financing or financial loans provided by the community. The community should improve access and utilisation by allocating funds to the private health institutions and they should set or specify a stipulated user fee that can be afforded by all community members. The community should also empower clients by creating profitable entrepreneurial businesses that will help clients cope financially with the medical expenses of the private health institutions. This view of implementing financial interventions is supported by WHO (2006:1).

The Private Public Partnership (PPP) for health in Nigeria was among the seven strategic objectives of the National Health Sector Reform (HSR) introduced by the Federal Ministry of Health (FMOH). The collaboration and partnership of both the private and public health care sectors was aimed at achieving effective, affordable and efficient health care services for all citizens (FMOH, 2005:8). Therefore, health care vouchers are an effective strategy that can address the issues of affordability and utilisation of private health institutions. Health care voucher enables the holder to utilise specific health care services at selected private health institutions. The federal government of Nigeria through FMOH should partner with selected private health institutions to provide low cost or free health care services to families that cannot afford medical fees by means of health care vouchers. The private health

institutions will provide health care services to clients with vouchers and the federal government will reimburse the private health institutions in future. Smith *et al*. (2001:34) and Jacobs, Ir, Bigdeli, Annear and Van Damme (2012:293) support this view.

Health equity funds are financial assistance provided by 'a third party payer' to facilitate access and utilisation of health care services for clients that cannot afford the medical fees in the private health institution (Jacobs *et al*., 2012:293). The private health institutions should partner with NGO's that are willing to provide financial assistance to clients that cannot pay for health care services in the private health institutions. This situation can address the issue of affordability of health care services in the private health institutions (Hardeman, Van Damme, Van Pelt, Por, Kimvan & Meessen, 2004:24).

Health insurance membership: Health insurance membership is significant and essential in protecting clients against financial risk of medical expenses incurred in a private health institution. Health insurance covers the medical expenses of health insurance clients and family members and it facilitates access and utilisation of the private health institutions. In order to address the barrier of access and utilisation created by insufficient personal income and affordability, the federal government of Nigeria, employers and community at large should provide health insurance coverage for the workforce and citizens. The federal government should speed up the process of the National Health Insurance Scheme (NHIS) to ensure universal coverage of the informal sector, retirees, vulnerable and unemployed citizens, and not only employees in the formal sector (employees that work for the federal, state and local government and private institutions). Mohammed, Bermejo, Souares, Sauerborn and Dong (2013:2) support this view.

Employers should provide health insurance coverage for their employees to enable them to have access to the private health institutions. Employers should partner with social or private health insurance companies to pay for medical expenses of their staff. Health insurance coverage provided by employers will enable clients to have access to and cope with the medical expenses of health care services for routine or prolonged chronic medications in the private health institutions. Stanton (2004:1)

endorses that the availability of health insurance provided by employers will create better health outcomes and lower the mortality rate of employees; it will discourage employees from using personal income to pay for health care services and it will increase access and utilisation of health care services.

Community-Based Health Insurance (CBHI) is also a significant resource that can address the issues of affordability and the utilisation of the private health institutions (Odeyemi, 2014:1). CBHI is responsible for providing financing for the total coverage of a wide range of health care services to members of a community. Therefore, to support CBHI, sufficient resources, financial support and contributions should be made by community members, non-governmental organisation and private health institutions. Through these methods, clients that cannot afford the private health institutions can access and utilise them (Kyomugisha, Buregyeya, Ekirapa, Mugisha & Bazeyo, 2009:59).

Reducing administrative cost, introducing financial interventions (community support, health care vouchers and health equity funds) and the provision of health insurance by employers can address the influence of personal income and affordability of health care services in the private health institutions.

7.5.3 Support sources

Clients require support sources (assistance) from family members and private health institutions to enable access and utilise health care services. The absence of support sources from family members and private health institutions makes it difficult for clients with insufficient personal income or no insurance coverage to access and utilise the private health institutions. Therefore, to facilitate clients' decision-making, it is recommended that the family members and private health institutions provide a variety of support sources.

Family financial support: Family financial support can encourage access and utilisation of health care services in the private health institutions. Family should provide emotional, informational and financial assistance to clients (Diaz *et al*., 2013:195). Financial assistance from family members is useful in overcoming the

barrier associated with the cost of health care and the utilisation of private health institutions during clients' financial crisis (Bakeera *et al*., 2009:8). Family members should pool financial resources to assist clients in the payment of health care services for routine medications and medical emergency. Furthermore, family members should support clients with family health insurance coverage to enhance access and utilisation of health care services in the private health institution. Scheppers *et al*. (2006:328) support this view.

Private health institutions should inform family members about the best way to provide emotional support to clients during prolonged and chronic illness. Private health institutions should provide informational support by educating family members about health and sex education as well as information regarding illness and diagnosis. Family members should provide assistance to clients by volunteering to be caregivers. This indicates that a family member of a client with an acute or chronic disease can willingly provide health care assistance without financial payment. The private health institutions should educate family members about medical activities, such as, tube feeding and ventilator care, bathing and dressing clients and how and when medication should be given to the client. Reinhard, Given, Petlick and Bernis (2008:1-2) and Timby and Smith (2013:65) support this view.

Private health institution staff support: Private health institutions should encourage staff and employees to provide support in the areas of language interpretation. This indicates that medication, treatment options and diagnosis should be translated by an interpreter into the language of the client so that the client can understand. The presence of an interpreter can enable clients to have effective communication and good dialogue with health care providers in the private health institutions. Health care providers in the private health institutions should also ensure that clients are familiar with the use of the technology of medical equipment. Information regarding the use of medical equipment reduces clients' fear and anxiety during treatment. Private health institutions should also ensure that quality health care services are delivered to all clients irrespective of their marital status. Scheppers *et al*., (2006:339) support this view.

Home or care giver is also a support source that private health institutions can offer clients. In other words, private health institution can assign staff or employees to provide home care support to clients who are married or not and cannot make it to the private health facility or clients who prefer to be treated at home. The care givers act as an interpreter, guide, companion and they provide emotional support and physical support to clients. The relationship between the care giver and clients reduces fear and worry associated with sickness (Timby & Smith, 2013:64).

Private health institution medical support: The private health institution should ensure that their facility is user friendly. In other words, the private health institutions should have a facility that supports the movement of the sick and the less privileged and encourages health care providers to move clients around within the institution with care. Private health institutions should place visible signs around the facility that assist the client's movement without asking for directions. Private health institutions should also ensure sufficient medical supplies (medication and medical equipment) and high quality medical equipment that will be used to deliver health care services to clients.

Transportation support: Transportation is an essential support source that can improve clients' access and utilisation of the private health institutions. Transportation support from private health institutions can assist clients to access and utilise health care services during financial crisis and medical emergency. Private health institutions should be aware that transportation for emergency and non-emergency situations can help clients to be punctual for appointments and treatments. Therefore, untimely death in the case of a chronic medical situation can be prevented or minimised. To improve access and utilisation of health care services, the private health institutions should provide an ambulance service that can function on the road, air and sea. Ambulance services provided by the private health institutions will enable clients with children and of all marital status, elderly, less privileged and lower income client to access and utilise the private health institutions. Syed, Gerber and Sharp (2013:976) support this view.

7.5.4 Customer satisfaction

The satisfaction of clients is paramount for the survival and growth of any business. Private health institutions should be aware that when their overall services delivery equals or exceeds clients' expectation, clients will be satisfied. In order to ensure the satisfaction of clients, private health institutions should improve the quality of services. Service quality refers to the degree of difference between a clients' expectation and the perceived service performance of the private health institutions (Mohammadi & Mohammadi, 2012:308).

Private health institutions should be aware that service quality in the delivery of health care services is linked to profitability, premium price, increased positive word-of-mouth and customer satisfaction (Bennett *et al*., 2003:77). Mohammadi and Mohammadi (2012:309) and Lovelock & Wirtz (2004:410) support that in order to increase customer satisfaction, private health institutions should ensure and enhance service quality.

Responsiveness: Private health institutions should manage overcrowding of consultation room. Clients should receive prompt services and a shorter waiting time. In other words, private health institutions should ensure that consultation rooms are not overcrowded and that clients of all ages and children are properly attended to and the length of stay is shortened without compromising the quality of services. Medical staff should be accessible, professional, willing to help and be able to listen attentively to clients' medical concerns. The private health institution should provide adequate information or feedback regarding the diagnosis, treatment options and how medication should be taken. Furthermore, medical staff in the private health institutions should never be too busy to attend to clients and should involve clients in the decision-making process regarding treatment options where possible.

Tangibles: The private health institution should ensure that medical equipment is adequate and of excellent quality. The service environment (interior and exterior) should be user friendly, neat, homelike, comfortable, odourless and the ambiance of the facility should be free of excessive noise. Private health institutions should ensure that their facility supports privacy for clients during treatment and rest. Private

health institutions should ensure that employees and staff are neat, respectful, kind, patient, professional, knowledgeable and competent.

Temperature, lighting and ventilation in the hospital facility should be appropriate to fit the needs of clients. Communication materials must portray friendliness and well-being. Visual and audio entertainment should be at minimal sound level not disturbing to manage client's waiting time. Light refreshments, such as, tea, coffee and water should also be available.

Reliability: The private health institutions should ensure that they have correct treatment and medication available. Furthermore, the private health institutions should ensure that the clients receive correct treatment and medication on time. Private health institutions should ensure that health care services are delivered to clients at the appointed time. Mistakes relating to diagnosis, treatments, medication and record keeping should be avoided.

Assurance: Private health institutions should keep medical records of clients private and secure. Private health providers should make clients feel comfortable and secure when sharing their medical information and history. Private health institutions should ensure that their staff have sufficient knowledge to provide adequate information regarding illness, treatments and medication to the understanding of clients.

Empathy: Private health institutions should ensure that their staff understand the medical needs and have the clients' interest at heart. Personal attention should be given to clients when it is called for it. The staff of the private health institutions should also feel compassion and sympathy when addressing the medical needs of clients. Private health institutions should also operate at hours appropriate to clients and their families.

7.5.5 Cognitive dissonance

Health care is an essential service that, when purchased, can create an improved health outcome or intensify an illness. Therefore, clients seek improved health outcomes by engaging in an intensive decision-making process. Their satisfaction, as a result of their decision-making process is crucial. Clients experience cognitive dissonance when the overall health care services delivery is less than what they expect.

Private health institutions should be aware that when clients experience cognitive dissonance regarding the quality of health care services purchased, they will be disappointed, suffer in silence, complain about poor service quality, stop using the services and spread negative word-of-mouth or switch service provider in the future (Lovelock & Wirtz, 2004:37). Bose and Sarker (2012:219), Hoffman *et al*. (2009:93) and Lovelock and Wirtz (2004:375) suggest that private health institutions should employ the following strategies to reduce cognitive dissonance.

Service quality: Private health institutions should ensure and improve quality services in their responsiveness, tangibles, reliability, assurance and empathy to clients. Private health institutions should ensure improvement in the quality of the interior and exterior of service facility, technology and equipment. Private health institutions should ensure that quality services are delivered at fair and affordable prices. Private health institutions should also ensure that similar quality of service is delivered across multiple locations. Private health institutions should understand that clients will be satisfied with the payment of medical fees if they are offered quality health care services. Costly medical fees for low quality services received might increase clients' cognitive dissonance.

Managing complaints and feedback: Private health institutions should create a platform that encourages clients to provide suggestions, feedback or complain easily. Private health institutions should handle the complaints of clients immediately and effectively and use the opinions of clients to improve service quality. Private health institutions should ensure that they compensate, reimburse, correct, apologise for mistakes and appreciate suggestions. This strategy can help private heath

institutions stay ahead of competition, retain dissatisfied clients, and make clients feel appreciated and special.

Minimise medical errors: Errors in the delivery of health care services are harmful and place clients at risk of worst health outcomes. Giving a client medicine that is not meant for a particular treatment of disease places the clients at risk. Private health institutions should minimise medical errors and mistakes related to treatment, surgical operations, diagnosis, medications, incorrect billing and record keeping. Clients can experience a high level of cognitive dissonance when the wrong treatment or surgical operation is carried out on them.

Customer services: Private health institutions should provide clients with extra customer service before and after purchase of health care services. Reassurance via email, mail and phone calls should be sent to clients to make them know that the right decisions have been made regarding the choice of health institutions. Private health institutions should ensure that they provide clients with detailed information regarding the health care services they seek to purchase. Private health institutions should provide clients with free check-ups after service delivery and contact clients regularly to ensure total recovery of health.

This strategy will make clients to feel that the private health institutions care about their satisfaction and improvement of their well-being. Private health institutions should send post cards, congratulatory messages, and health care magazines to reassure clients that they made the right choice.

Effective marketing strategy: Clients are sometimes faced with conflicting messages from family, friends, media and advertising regarding the superiority of other health institutions that would have been utilised instead of the one selected. Cognitive dissonance is likely to arise when clients are faced with these situations. Private health institutions should reduce clients' cognitive dissonance by reinforcing clients' decision through effective marketing strategy. Private health institutions should employ effective marketing strategy that reassures clients of the superiority of their purchase. This situation can uphold the prestige of clients.

Creating value: Creating health care services that clients value and need can help reduce cognitive dissonance. Private health institutions should come up with health care programmes that are targeted to meet the needs of clients. Private health institutions should also uphold their values by promising and delivering quality health care services.

Staff training: Private health institutions can reduce cognitive dissonance by training employees on how to satisfy clients, handle complaint effectively, perform assigned tasks and meet the individual needs of clients. Private health institutions should train frontline and customer services staff on how to manage clients and deliver quality service. Private health institutions should also ensure that they match each staff to positions that fit their abilities and skills.

Extensive research: The private health institutions should use the level of feedback and complaints to assess if clients are satisfied or dissatisfied with their service delivery and quality. In the case of doubt and dissatisfaction, private health institutions should carry out extensive research to identify the cause of clients' cognitive dissonance. Immediately, private health institutions should employ strategies to reduce it. This strategy can help private health institutions correct their mistakes, increase satisfaction and retain existing clients.

7.6 CONTRIBUTION OF THE STUDY

This study contributes to knowledge by providing a theoretical model that can assist the private health institutions to understand the decision-making process of clients. Private health institutions can also use the theoretical model to identify and manage customer satisfaction and cognitive dissonance. Through empirical results, this study contributes to knowledge by expanding the current understanding of the influencing factors of the decision-making process regarding the utilisation of private health institutions in Nigeria as no other study of this nature has been done.

The results of this study add a valuable contribution to the body of knowledge, in that it provides information about how marketers and private health institutions in Nigeria can understand the process of clients' decision-making and the types of purchase

decisions that clients consider when purchasing health care services. Literature of this study revealed that understanding the decision-making process will enable private health institutions to identify competitors through the clients' evoked set of alternatives, craft effective marketing strategies, and ensure quality performance during the clients' service encounter experience.

Further, this study is a significant contribution to the body of knowledge because it reveals the benefits associated with the use of medical schemes in Nigeria. In other words, the availability of medical schemes will promote access to private health care facilities and it will enable cost saving for clients' with limited resources. Literature in this study reveals that improved access into the private health institutions by means of medical schemes will discourage clients from using personal income for the payment of medical fees. Furthermore, access to the private health institutions will reduce overcrowding at public health institutions. Due to enhanced access by means of medical schemes, public and private health care providers will be in a competition to enhance service quality and performance in order to attract and retain clients.

Furthermore, the results of this study have contributed to literature by revealing how private health institutions in Nigeria can retain existing and attract new clients through the improvement of quality in the delivery of health care services. Empirical results of this study provide strategies of the improvement of quality in the overall service that can create satisfaction and better health outcomes for clients in Nigeria.

7.7 LIMITATIONS OF THE STUDY AND FUTURE RESEARCH

This study has various limitations. These are time constraint, financial constraint, respondent's slow response, incomplete questionnaire (missing data), lack of discriminant validity of vital dimensions used in this study and direct focus on the private health institutions in Lagos state, Nigeria. This study was limited by time constraint in such a way that every stage of the study was planned according to a stipulated time frame.

Furthermore, this study was limited by the slow completion of questionnaires by respondents. In order to achieve the collection of primary data from the sample size

(450) of the study, more than four hundred and fifty questionnaires were distributed because the majority of the respondents misplaced the questionnaires given to them and some were slow in completing the questionnaire. This study also experienced the limitation of incomplete data. This indicates that some questionnaires were not fully completed by respondents and, as a result, they were discarded and not used. These limitations resulted in additional funding which was provided for the printing of more questionnaires to gather data from the targeted sample size of the study.

Furthermore, the limitation of the study was the lack of discriminant validity of some items used. This indicates that some items did not measure what they were supposed to measure and others did not load to a significant discriminant validity of 0.4. Items that lacked discriminant validity were deleted, vital dimensions used in this study were lost and latent variables were created. Due to time and financial constraints, this study focused on investigating the influencing factors of decision-making process regarding the private health institutions in Lagos state, Nigeria. However, this study can be carried out in the public health institutions or other private health institution in other states in Nigeria in the future.

This study recommends that future research should explore and engage in investigating other influencing factors of the decision-making process regarding the private health institutions. Future research could also refine the understanding of customer satisfaction and cognitive dissonance in relation with decision-making process regarding the private health institutions and other services institutions in Nigeria. Future research on strategies focusing on how ways overcome financial constraints in the payment of medical expenses could also be explored.

7.8 CONCLUSION

This study set out to investigate the influencing factors of the decision-making process regarding utilisation of private health institution as well as the satisfaction and cognitive dissonance of clients towards health care services. The empirical results of this study indicate that certain influences such as service encounter experience, personal income and support sources have a significant positive relationship with the decision-making process regarding the utilisation of private

health institutions. Furthermore, the decision-making process also has a significant positive relationship with customer satisfaction and cognitive dissonance.

The influential factors that have been identified through the empirical results will enlighten researchers and the private health institutions on issues that influence the clients' decisions to utilise private health institutions. The well-being and satisfaction of clients will be enhanced if the private health institutions can craft effective strategies that will enable clients to gain easy access and utilise health care services. This study emphasised that access to and utilisation of health care services in the private health institutions can be granted to clients through personal income and support sources from family members and private health institutions. This study reveals that health insurance coverage is an effective way that will help clients overcome the financial constraints and restricted access to and utilisation of private health institutions.

Furthermore, improvement of the overall services performance is important to keep clients satisfied and help in the improvement of health outcomes. In other words, the well-being and satisfaction of clients will be enhanced if private health institutions as well as the Nigerian health system improve the areas of ambulance services, medical interpreters, knowledgeable medical practitioners, effective communication, shared decision-making, medical insurance and quality medical equipment. Failure to improve the overall quality and performances of the health care services in the private health institutions can lead to clients' cognitive dissonance. Due to the disappointment and unhappiness with the overall services received, clients are likely to spread bad word-of-mouth and engage in a more intense decision-making process when the need for health care services arises.

Finally, marketers, health systems, private and public health institutions should understand the influence of and engage in the stages, of the clients' decision-making process. This understanding will enable them understand what clients value and need and, therefore, how well to satisfy them and reduce cognitive dissonance. Easy access and utilisation of the private health institutions as well as satisfaction in quality health care delivery will create better health outcomes for the workforce and citizens of a country and this will improve economic development.

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ANNEXURE A:

Sample Cover Letter

Nelson Mandela Metropolitan University

for tomorrow

Unit for Applied Management Sciences
Summerstrand South Campus
DEPARTMENT OF BUSINESS MANAGEMENT
Tel. +27 (0)41 504 2875 Fax. +27 (0)41 504 4840

April 2014

Dear Respondent

I am student of the Nelson Mandela Metropolitan University in Port Elizabeth, South Africa. I am currently studying towards a Masters Degree in the faculty of Business and Economic Sciences. I am conducting a research on factors that influence the consumer decision-making process regarding the utilisation of private health care institutions in Nigeria.

The private health care institution is one of the major providers of health care services in Nigeria. The provision of quality and affordable health care services by the private health care institutions is paramount for the well-being of all citizens and workforce of a country. Therefore, to improve the services of the private health institutions, it is crucial to identify several factors that make clients decide to utilise the private health care institutions. Furthermore, it is important to assess whether clients are satisfied or dissatisfied with the health care services provided by the private health care institutions. This study will help identify factors that influence client's decision to use the private health care institutions. This study will also help private health care institutions to improve their service delivery.

It would be greatly appreciated if you could assist with the completion of this questionnaire so as to make the research study a success. Please note that the information provided will be strictly confidential and will be used only for research purposes.

Kind regards

Prof NE Mazibuko and Dr J Kruger — **Research coordinators**

Ms B.V Akponah — **Researcher**

ANNEXURE B:

Sample Questionnaire

QUESTIONNAIRE

This questionnaire comprises two sections. Section A investigates perceptions regarding privatisation on a five-point scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). Please indicate the extent to which you agree with these statements by means of a cross (X) in the appropriate block. Section B seeks to solicit biographical information from respondents. Please indicate your response to the options provided by making a cross (X) in the appropriate block.

		STRONGLY DISAGREE	DISAGREE	INDIFFERENT	AGREE	STRONGLY AGREE
	I believe that …					
1	it is difficult for the elderly to find someone to help him/her get to the private health care institutions.	1	2	3	4	5
2	it is difficult for the elderly to find transportation to the private health care institution.	1	2	3	4	5
3	for my child, I can easily gain access to the private health care institutions, in the event of sickness.	1	2	3	4	5
4	as an elderly, I can easily gain access to the private health care institutions.	1	2	3	4	5
5	the private health care institution provides quality care for all different ages according to the life-cycle stages.	1	2	3	4	5
6	the private health care institutions provide specific care for children.	1	2	3	4	5
7	young medical practitioners in the private health care institution are more caring.	1	2	3	4	5
8	to be treated by a male medical practitioner in the presence of a female health care assistant in the private health care institutions is acceptable.	1	2	3	4	5
9	sharing one's illness with the doctors regardless of their gender in the private health care institutions is acceptable.	1	2	3	4	5
10	women use more health care services than men.	1	2	3	4	5
11	the private health care institutions provide better maternity services than the public health institutions.	1	2	3	4	5
12	woman medical practitioners are willing to provide more information about medical concerns in the private health care institutions than men.	1	2	3	4	5
13	male medical practitioners in the private health care institutions are more understanding and caring than women counterparts.	1	2	3	4	5
14	male medical practitioners are better qualified than female medical practitioners in the private health care institutions.	1	2	3	4	5
15	the private health care institutions provide quality health care services to clients who have lost their spouse/partner.	1	2	3	4	5

16	marital status determines the extent of health care services that can be offered by the health care institutions.	1	2	3	4	5
17	speaking about one's illness to a medical practitioner in the presence of the spouse/partner at the private health care institutions is acceptable.	1	2	3	4	5
18	speaking about one's illness to a medical practitioner without a family member present at the private health care institutions is acceptable.	1	2	3	4	5
19	the consent of a spouse/partner is of utmost importance before the commencement of treatment for a life-threatening condition at the private health care institutions.	1	2	3	4	5
20	spousal/partner dependence leads to limited medical options at the private health care institutions.	1	2	3	4	5
21	I will use the private health care institutions because of the benefits that are offered to my spouse/partner when I am admitted.	1	2	3	4	5
22	the medical staff at the private health care institutions explain things clearly to me if I do not understand the medical terms regarding my diagnosis.	1	2	3	4	5
23	the medical staff at the private health care institutions is professional and calm when dealing with stressful situations.	1	2	3	4	5
24	the medical staff at the private health care institutions will always offer extra assistance.	1	2	3	4	5
25	the medical practitioners at the private health care institutions are competent in their jobs.	1	2	3	4	5
26	an interpreter is available at the private health care institutions to ensure that I understand the medical treatment and instructions.	1	2	3	4	5
27	the medical staff at the private health care institutions are multi-skilled.	1	2	3	4	5
28	the medical staff at the private health care institutions are proficient.	1	2	3	4	5
29	the medical staff at the private health care institutions ensure that I am familiar with the use of medical equipment.	1	2	3	4	5
30	the medical staff at the private health care institutions ensure that I am familiar with the use of medical technology.	1	2	3	4	5
31	my knowledge of quality health care services enables me to choose the private health care institution.	1	2	3	4	5
32	my educational level helps me to decide on utilising the private health institution.	1	2	3	4	5
33	if I am relieved of my job, I will not be able to utilise the private health care institutions.	1	2	3	4	5
34	my occupation provides sufficient income that enables me to utilise the private health care institutions.	1	2	3	4	5

35	private health care is required due to the nature of my job.	1	2	3	4	5
36	the occupational policy in my job prescribes that all medical allowances should be used only in the private health care institutions.	1	2	3	4	5
37	occupational categories are offered different medical services at the private health care institutions.	1	2	3	4	5
38	the private health care institutions provide good antenatal care for women.	1	2	3	4	5
39	it is difficult for people with a large family size of more than four to afford the services of the private health care institutions.	1	2	3	4	5
40	it is comfortable for me to pay for health care services from a private health care institution for a family size less than four.	1	2	3	4	5
41	I can still purchase generic medication for my family from the public chemist/pharmacy even if I am a regular client of the private health care institutions.	1	2	3	4	5
42	it is difficult for me to obtain chronic medication for my large family of more than four from the private health care institutions.	1	2	3	4	5
43	the use of health care services from the private health care institutions contradicts my religious beliefs.	1	2	3	4	5
44	the supernatural force maintains my health.	1	2	3	4	5
45	healing from the medical practitioner is more effective than treatment from supernatural forces.	1	2	3	4	5
46	healing from supernatural force is more effective than treatment from private health care institutions.	1	2	3	4	5
47	although my religion is flexible, specific treatments in the private health care facility are in direct conflict with my religious beliefs.	1	2	3	4	5
48	the private health care institutions provide better quality health care than the public health care institutions.	1	2	3	4	5
49	the private health care institutions have medical practitioners who have more medical expertise.	1	2	3	4	5
50	the staff at the private health care institutions are always willing to assist me.	1	2	3	4	5
51	the staff at the private health care institutions are knowledgeable about health care services.	1	2	3	4	5
52	utilising the private health care institutions gives me prestigious status within my community.	1	2	3	4	5
53	it is not an embarrassment to reveal my illnesses to medical practitioners in the private health institution.	1	2	3	4	5
54	owning a medical insurance grants me easy access to private health care institutions.	1	2	3	4	5
55	traditional methods of treatment are more effective than treatment from the private health	1	2	3	4	5

	care institutions.					
56	It is easier to obtain medication from the chemist/pharmacy than it is from the private health care institutions.	1	2	3	4	5
57	the chemist/pharmacy provides quicker health care services than the private health care institutions.	1	2	3	4	5
58	my income is sufficient to pay my medical fees in the private health care institutions.	1	2	3	4	5
59	my income is sufficient to pay my family's medical fees in the private health care institutions.	1	2	3	4	5
60	if I have an increment in my salary, I will use the private health care institutions.	1	2	3	4	5
61	the private health care institutions are affordable therefore I use their services.	1	2	3	4	5
62	I will obtain generic medication from the public chemist/pharmacy although I receive health care from the private health care institutions.	1	2	3	4	5
63	my income is sufficient to cater for prolonged chronic medication obtained from the private health care institutions.	1	2	3	4	5
64	if I have a personal medical insurance, it will help me obtain easy access to the private health care institution.	1	2	3	4	5
65	my job provides the medical insurance that enables me to have access to the private health care institutions.	1	2	3	4	5
66	having medical insurance enables me to receive medical attention quicker from the private health care institutions.	1	2	3	4	5
67	having medical insurance ensures that my family receives medical attention quickly from the private health care institutions.	1	2	3	4	5
68	because I have medical insurance, there is no need for me to make a personal payment in an emergency situation at the private health care institutions.	1	2	3	4	5
69	a medical insurance ensures that the private health care institutions provide me with a medications script which I can use at any chemist/pharmacy.	1	2	3	4	5
70	a medical insurance ensures that I have access to a variety of benefits at the private health care institutions to cater for my medical needs.	1	2	3	4	5
71	a medical insurance ensures that my family has access to a variety of benefits at the private health care institutions to cater for their medical needs.	1	2	3	4	5
72	I receive financial support from my family members to enable me to utilise the private health care institutions.	1	2	3	4	5
73	in the event of financial crisis, several family members will help with the paying of my	1	2	3	4	5

	medical bills in the private health care institutions.					
74	in the event of financial crisis, several family members will help with paying the bills for a medical emergency in the private health care institutions.	1	2	3	4	5
75	I can visit the private health care institutions, because I am covered by my family's medical insurance.	1	2	3	4	5
76	all vulnerable members in my family, such as women and children, are financially supported when they attend private health care institutions.	1	2	3	4	5
	I make a decision to use the private health care institution, because …					
77	I am familiar with the institution.	1	2	3	4	5
78	it is located close to my house.	1	2	3	4	5
79	it provides me with feedback regarding my illnesses.	1	2	3	4	5
80	the medical practitioners pay attention to my medical concerns.	1	2	3	4	5
81	the medical practitioners are concerned about my medical uncertainties.	1	2	3	4	5
82	the medical costs are affordable.	1	2	3	4	5
83	of the benefits that the institution offers.	1	2	3	4	5
84	information about treatment options is available.	1	2	3	4	5
85	the clients are able to decide and negotiate their preferred treatment.	1	2	3	4	5
	I am satisfied with …					
86	the appearance and functionality of the private health care institution.	1	2	3	4	5
87	the responsiveness of the staff at the private health care institution.	1	2	3	4	5
88	the degree of knowledge of the medical practitioners at the private health care institutions.	1	2	3	4	5
89	the professionalism of the staff at the private health care institution.	1	2	3	4	5
90	the effort of the medical staff at the private health care institution in ensuring that I understand how to take my medication.	1	2	3	4	5
91	how they entertain me while I am waiting for my medical treatment at the private health care institution.	1	2	3	4	5
92	the privacy that the private health care institution facility provide me.	1	2	3	4	5
93	how the private health care institution manages overcrowding of consultation rooms.	1	2	3	4	5
94	the ambiance of the medical care facilities that is free of excessive noise at the private health care institution.	1	2	3	4	5
95	the odour of the private health care facility.	1	2	3	4	5
96	the medical personnel in the private health care institution because they are kind .	1	2	3	4	5

97	the medical personnel in the private health care institution because they treat me with respect.	1	2	3	4	5
	I revisit the private health care institution because…					
98	of the excellent competency of the staff.	1	2	3	4	5
99	whenever I get ill unexpectedly.	1	2	3	4	5
100	the staff is friendly.	1	2	3	4	5
101	of the good quality treatment and medication received.	1	2	3	4	5
102	I feel that the service received is money well spent.	1	2	3	4	5
103	of the prestige it provides me .	1	2	3	4	5
104	of its attractive interior décor.	1	2	3	4	5
105	of its outer appearance.	1	2	3	4	5

1. PLEASE INDICATE YOUR GENDER

Male	1	Female	2

2. PLEASE INDICATE YOUR AGE

20-29	1	30-39	2	40-49	3	50-59	4	60+YRS	5

3. PLEASE INDICATE YOUR LEVEL OF MONTHLY INCOME

1	**2**	**3**	**4**	**5**	**6**	**7**
₦1000 - ₦20, 000	₦21, 001 - ₦40, 000	₦41, 001 - ₦60, 000	₦ 61, 001 - ₦80, 000	₦81, 001 - ₦100, 000	₦101, 001 - ₦120, 000	₦ 120, 001 and above

4. PLEASE INDICATE YOUR MARITAL STATUS

Single	1	Married	2	Divorced	3	Widowed	4	Co-habitant	5

5. PLEASE INDICATE YOUR FAMILY SIZE

1	1	2-4	2	5-7	3	8-10	4	11 +	5

6. PLEASE INDICATE YOUR LEVEL OF EDUCATION

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
No formal education	Primary school	Junior secondary	Secondary school	Diploma	Undergraduate degree	Post-graduate degree	Others please specify

7. PLEASE INDICATE THE NATURE OF YOUR FIELD

Manufacturing	**1**	Retailing	**2**	Wholesaling	**3**	Services	**4**	Other	**5**

8. PLEASE INDICATE YOUR OCCUPATION

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
General worker	Supervisor	Foreman	Admin C/Secretary	Assistant Manager	Manager	CEO/ General Manager	Self-employed

9. PLEASE INDICATE YOUR RELIGION

Christian	**1**	Islamic	**2**	Other, specify	**3**

THANK YOU FOR YOUR TIME AND COOPERATION

ANNEXURE C:

Language Editing Letter

Nelson Mandela Metropolitan University

for tomorrow

11 November 2014

DECLARATION: LANGUAGE PRACTITIONER

This is to confirm that Mrs Vuyiswa Melrose Maqagi edited the dissertation entitled **Factors influencing consumer decision making process in the private health institutions** by Voke Blessing Akponah, for language editorial errors.

Mrs Vuyiswa Melrose Maqagi

Lecturer: Department of English Studies

Faculty of Arts

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Tel: +27 41 504 2745

Cell: 0822022357

ANNEXURE D:

Ethics Clearance

Nelson Mandela Metropolitan University
for tomorrow

ETHICS CLEARANCE FOR TREATISES/DISSERTATIONS/THESES

Please type or complete in black ink

FACULTY: Business and Economic Sciences_____

SCHOOL/DEPARTMENT: Business Management_____

I, (surname and initials of supervisor) Mazibuko N.E._____

the supervisor for (surname and initials of candidate): Akponah V. B. _____

_____ (student number) 212385240 _____

a candidate for the degree of Master of Commerce (Research)

_____

with a treatise/dissertation/thesis entitled (full title of treatise/dissertation/thesis):

_ Factors influencing consumer decision making process in the private health institutions _____

considered the following ethics criteria *(please tick the appropriate block):*

	YES	NO
1. Is there any risk of harm, embarrassment of offence, however slight or temporary, to the participant, third parties or to the communities at large?		X
2. Is the study based on a research population defined as 'vulnerable' in terms of age, physical characteristics and/or disease status?		X
2.1 Are subjects/participants/respondents of your study:		
(a) Children under the age of 18?		X
(b) NMMU staff?		X
(c) NMMU students?		X
(d) The elderly/persons over the age of 60?		X
(e) A sample from an institution (e.g. hospital/school)?		X
(f) Handicapped (e.g. mentally or physically)?		X
3. Does the data that will be collected require consent of an institutional authority for this study? (An institutional authority refers to an organisation that is established by government to protect vulnerable people)		X
3.1 Are you intending to access participant data from an existing, stored repository (e.g. school, institutional or university records)?		X
4. Will the participant's privacy, anonymity or confidentiality be compromised?		X
4.1 Are you administering a questionnaire/survey that:		
(a) Collects sensitive/identifiable data from participants?		X
(b) Does not guarantee the anonymity of the participant?		X
(c) Does not guarantee the confidentiality of the participant and the data?		X
(d) Will offer an incentive to respondents to participate, i.e. a lucky draw or any other prize?		X
(e) Will create doubt whether sample control measures are in place?		X
(f) Will be distributed electronically via email (and requesting an email response)? Note: • If your questionnaire **DOES NOT** request respondents' identification, is distributed electronically and you request respondents to return it *manually* (print out and deliver/mail); **AND** respondent anonymity can be guaranteed, your answer will be NO. • If your questionnaire **DOES NOT** request respondents' identification,		X

is *distributed via an email link and works through a web response system (e.g. the university survey system);* ***AND*** respondent anonymity can be guaranteed, your answer will be NO.		

*Please note that if **ANY** of the questions above have been answered in the affirmative **(YES)** the student will need to complete the full ethics clearance form (REC-H application) and submit it with the relevant documentation to the Faculty RECH (Ethics) representative.*

and hereby certify that the student has given his/her research ethical consideration and full ethics approval is not required.

_____ _____

SUPERVISOR(S) **DATE**

_____ _____

HEAD OF DEPARTMENT **DATE**

_____ _____

STUDENT(S) **DATE**

Please ensure that the research methodology section from the proposal is attached to this form.